

DOCTORAL THESIS

Clinical Implications of Counselling Psychologists' Responses to Client Trauma: An Interpretative Phenomenological Analysis

Merriman, Olivia

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**Clinical Implications of Counselling Psychologists' Responses to Client Trauma:
An Interpretative Phenomenological Analysis**

By

Olivia Lindsay Merriman (BA, PG Dip, MA)

*A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of
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**Department of Psychology
University of Roehampton**

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1.0 ABSTRACT

Background and aims: The past two decades have seen a surge of interest in the impact of working with trauma on psychological therapists' well-being. However, the implications of therapists' responses to trauma for the process of therapy are unknown. The existing literature carries the assumption that therapists' strong subjective responses to traumatic material have a negative impact on the therapeutic process, but this has not been directly researched. Therefore, this thesis investigates the experiences of therapists working with clients who describe traumatic events, and how therapists consider their responses to the disclosure of traumatic material to have impacted upon the therapeutic process.

Method: Semi-structured interviews were carried out with nine qualified chartered counselling psychologists with experience of working with trauma. Interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA).

Results: The analysis produced four superordinate themes. These were: (1) Demands and challenges in the use of self in response to trauma; (2) Dimensions of complexity in working with trauma: Conceptual, contextual, ethical, political; (3) Developing the therapeutic self in response to trauma; and (4) Valuing the therapeutic self in work with trauma.

Conclusion: The research indicated that significant challenges were experienced in terms of the complex interpersonal dynamics, troubling somatic processes and ethical dilemmas in therapy with trauma. Furthermore, existing theoretical models were not sufficient to illuminate practice in these areas. Thus, this research indicates that specific

training and development in these areas is warranted, and a possible theoretical framework to help facilitate this is proposed. In addition, the current research supports the development of more explicitly socially contextualised approaches to trauma. Future research could usefully build on the current study by further investigating embodied processes and interpersonal dynamics, as well as the impact of therapists' disclosure of their subjective responses in therapy with trauma.

2.0 CHAPTER ONE

2.1 INTRODUCTION

What becomes apparent when reading the literature on psychological trauma is that it is a subject that both fascinates and repulses... [O]nce clinicians actually experienc[e] the emotions aroused by the traumatic experiences of their patients they either ha[ve] to flee or defend themselves.

De Zulueta (2006, p. 183)

Within counselling psychology, the reflective use of self in therapy is listed as a core competency, and therapists' appreciation of subjective and intersubjective factors is highly valued. In therapy with trauma, research highlights the importance of non-specific factors, which are underpinned by the therapist's use of self, to therapeutic outcome. However, empirical literature also indicates that working with trauma has a negative psychological impact on the therapist, and researchers have argued that therapists' strong subjective responses to traumatic material have a detrimental impact on the therapeutic process (e.g. Neumann & Gamble, 1995). This highlights potential challenges to the therapeutic use of self in therapy with trauma, yet the topic has not been directly investigated to date.

In addition, research thus far has arguably been limited by an uncritical acceptance of the modernist conceptualisation of trauma as defined by the diagnostic category of 'post-traumatic stress disorder' in DSM-IV, and a lack of consideration for intersubjective approaches to trauma. From an intersubjective stance, trauma is not defined by the event itself, but rather, by how a distressing experience is meaningful to an individual, or

community, within a particular relational and socio-cultural context (Bracken, 2002). Therefore, informed by intersubjectivity theory, this research investigates the experiences of therapists working with clients who describe traumatic events, and how therapists consider their responses to the disclosure of traumatic material to impact upon the therapeutic process. It is intended that research into this topic will contribute to the research base on clinical work in therapy with trauma, specifically by enriching our understanding of processes underpinned by the therapeutic use of self in therapy with trauma that help or hinder the therapeutic process, as well as potential obstacles to the effective therapeutic use of self.

In this chapter, the history of psychological trauma as a concept is outlined in order to contextualise current understandings of trauma. This is followed by a discussion of some of the conceptual debates in the field of trauma, and of research findings on approaches to working with trauma. A selection of the literature theorising the impact of the therapist's subjectivity on trauma work is then examined, and the (limited) findings on the impact of therapists' responses to working therapeutically with trauma are explored. The introduction concludes with a rationale and aim for the current study, including the choice of Interpretative Phenomenological Analysis (IPA) to address this research question.

2.2 LITERATURE REVIEW

2.2.1 The concept of psychological trauma

Cachia (2010) notes that the word 'trauma' is of ancient Greek derivation, meaning wound, damage or defeat. Prior to the nineteenth century, the word signified a bodily wound usually received during war, however with the development of empirical approaches to the mind, trauma was "psychologised" (Fierke, 2007, p. 125). The investigation of trauma began with an interest in unexplained somatic symptoms in people labelled as 'hysterics' and accident victims, and debates about whether they had psychological or biological origins (van der Kolk, McFarlane & Weisaeth, 1996, p.x). In 1859, Briquet, a French psychiatrist, began to link hysterical symptoms with histories of childhood trauma, and Pierre Janet, the French philosopher, psychiatrist and psychotherapist, developed this idea further (van der Kolk, Weisaeth & van der Hart, 1996). Janet held that being aware of one's personal history as well as accurately perceiving the present situation dictates how well a person is able to react to stress, stating that hysterics were not able to mobilise their inner resources to determine appropriate or helpful behaviour (ibid.). Janet theorised that when experiencing extreme emotions, people may be unable to link the distressing events with their current 'cognitive schemes' and therefore these memories are not incorporated into their narrative but are dissociated from consciousness (ibid.).

Janet's theory of the impact of trauma on memory and mind was largely accepted until the advent of psychoanalysis (ibid.). Whilst Freud originally stated that childhood sexual abuse was directly related to the genesis of hysteria, he later rejected this conceptualisation and formed the notion of the 'defence hysteria' where:

[I]t is not the actual memories of childhood trauma that are split off from consciousness, but rather the unacceptable sexual and aggressive wishes of the

child, which threaten the ego and motivate defences against the conscious awareness of these wishes.

van der Kolk, Weisaeth & van der Hart (1996, p. 54).

The same authors argue that as the field of psychiatry aligned itself with a Freudian conceptualisation of mental processes, fantasy was emphasised over life experiences, and Janet's contribution to the understanding of trauma was bypassed.

The diagnosis most closely associated with trauma – post-traumatic stress disorder (PTSD) – was incorporated into the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association in 1980. Micale and Lerner (2001) state that this was partially as a result of lobbying on behalf of veterans of Vietnam; “this diagnosis acknowledged and dignified their suffering” (p. 4). Micale and Lerner argue that considering the disasters of the twentieth century it is understandable that trauma has become of increasing interest. According to Herman (2001), our current conceptualisation of trauma is based on the three areas: hysteria, shell shock, and sexual and domestic violence, and each of these areas of trauma has been associated with a political movement. Defined by the DSM-IV-TR (American Psychological Association, 2000) PTSD is held to result from exposure to a traumatic event that causes actual or threatened death or injury to self or others and involves “intense fear, helplessness or horror”. The list of potentially traumatic events provided by the DSM-IV-TR includes: sexual and physical assault, robbery, being kidnapped, being taken hostage, terrorist attacks, torture, disasters, severe automobile accidents, and life-threatening illnesses, as well as witnessing death or serious injury by violent assault, accidents, war or disaster (Briere & Scott, 2006). In addition, the same authors note that there are various other

diagnoses and symptoms that have been associated with trauma, including depression, anxiety, somatoform response, dissociation disorders, substance misuse and borderline personality disorder.

Briere and Scott (2006) argue that a list of symptoms and disorders cannot capture the entirety of the impact of psychological trauma on a person, in that trauma can result in significant ruptures in the meanings we hold about our lives and can lead to feelings and internal changes that diagnoses do not encompass: “These more existential impacts include profound emptiness, loss of connection with one’s spirituality, or disruption in one’s ability to hope, trust or care about oneself or others” (Herman, cited in Briere & Scott, 2006, p. 17). Therefore the current research does not draw on the limited conceptualisation of trauma as defined by the diagnostic category of ‘PTSD’. How, then, might trauma be understood? The following section discusses current debates concerning the concept of trauma, and concludes by developing an intersubjective understanding of trauma.

2.2.2 Conceptual debates concerning trauma

Micale and Lerner (2001) argue that since there is such a variety of events that are considered traumatic and, further, such a range of different responses to events considered traumatic, it “seems impossible to define trauma by external, objective criteria” (p. 20). On the other hand, O’Brien (1998) notes that some events such as combat and violent crime are more likely to lead to psychological distress and for some events there is a positive relationship between the magnitude of the event and severity of

symptoms, which provides some support for the notion of being able to class some incidents as potentially more ‘traumatic’ than others. Similarly, Briere and Scott (2006) highlight research evidence that particular characteristics of traumatic events have been shown to have an impact on the post-traumatic response, including intentional violence, sexual violence and the presence of life threat, amongst other factors (p. 16).

A further theoretical consideration relates to the debate within the field of trauma about the value of making a distinction between ‘simple’ and ‘complex’ trauma (Herman, 2001). While simple trauma is conceptualised as a one-off traumatic event as encapsulated by DSM IV, complex trauma is the experience of repeated, cumulative trauma, as might be experienced by a prisoner of war, or in domestic violence (Schottenbauer et al., 2008). Schottenbauer et al. (2008) highlight that research evidence supports this distinction in that “there are significant differences in mental health between persons who experienced one-time trauma and those with cumulative histories of trauma” (p. 14). Jordan (2010) developed the concept of ‘relational trauma’, including physical, sexual, financial and emotional abuse, as an adjunct to complex trauma. Relational trauma occurs in intimate relationships when one person in a position of power uses that power over the other person with detrimental effect, involving a profound sense of “betrayal of relationship” (Jordan, 2010, p. 236). Thus, rather than focussing on the impact of isolated traumatic events on passive individuals, we are encouraged to consider the way in which traumatic events are meaningful to a person in the course of their development over the life-span, including previous traumatic or abusive experiences.

In addition, the role of the individual's personal characteristics and their social environment have been found to play a part in the response to potentially traumatic events: so-called 'victim-variables' include less functional coping styles, having a previous history of trauma, and being from a social group more frequently exposed to emotionally disturbing events, including those from an economically deprived background, ethnic minority groups and women (Briere & Scott, 2006). In terms of social support, research indicates that the way in which people around the victim respond to their traumatic experience is one of the most influential factors in terms of the response to the trauma (ibid.). This also indicates the importance of relational support to recovery from trauma, and thus the centrality of the therapeutic relationship in therapy for trauma (ibid.). Thus, research evidence highlights the inextricably social and contextual nature of trauma – and while the characteristics of the event are important, so is the relational context, including both social support and the demographic status of the individual. This emphasises the impossibility of fixing a definitive, objective conceptualisation of what constitutes 'trauma'.

Bracken (2001, 2002) argues that traumatic responses have been mistakenly viewed to be universally valid with consistent symptoms, irrespective of historical or cultural period. For example, van der Kolk, Weisaeth and van der Hart (1996) state that experiences of overwhelming horror have always led to disturbing memories, avoidance and physiological arousal – right from the time of Homer to today (p. 47). However, Micale and Lerner (2001), Young (1995) and Bracken (2001, 2002), amongst others, critique the notion that 'post-traumatic psychopathology' is timeless and universal. Bracken (2001) argues that the characteristics of shell shock, such as spasms, blindness

and muteness, do not in fact concur with symptoms of PTSD. In 'The Harmony of Illusions' (1995), Young reaches a similar conclusion, that whilst the pain and suffering that people experience following horrific events is real, the facts now associated with PTSD / psychological trauma are not 'true' or timeless as such, but are constructed through prevailing scientific (and cultural) discourses (p. 10). Summerfield (1999) argues that the concept of PTSD is a reflection of the wider trend within Western cultures to medicalise emotional pain, the result of which is a distraction from a social understanding of war in terms of human lives and a move towards a pathologising medical perspective. These strong critiques of modernist notions of trauma highlight the importance of recognising the cultural and historical specificity of responses to horrifying events and the dangers of uncritically treating such responses as a psychiatric illness. The implications of these critiques of modernist notions of trauma for working therapeutically with traumatic material are considered in greater depth later in this review.

On the other hand, writers such as Herman (2001) and De Zulueta (2006) are of the view that what has come about is the *recognition* of the psychological impact of trauma:

It took a devastating war and the defeat of a world power, with all the internal social and political consequences of this disaster, for psychological trauma to begin to be recognized for what it is, the wounding of the human psyche during states of terrifying helplessness.

De Zulueta (2006, p. 193)

Further, the same authors critique the historical lack of recognition of people's traumatic experiences, stating that psychiatry has alternated from being fascinated by trauma to resolutely ignoring their patients' biographical experiences in the contexts of their distress. Indeed, Read et al. (2007) highlight that only three decades ago, a major textbook in psychiatry stated that the rates of incest were one in a million. They also review research which indicates that a high proportion of people who use mental health services never disclose their traumatic pasts to clinicians, demonstrating a disinclination both to enquire about trauma and to disclose it (Finkelhor, 1990; Elliott, 1997). Read et al. (2007) note that even if one disputes the relevance of trauma to subsequent distress, mental health services users themselves highlight that they feel their traumatic experiences are important and therefore should be given due consideration within therapeutic work.

A further theoretical complexity relates to issues of morality and conscience that arise in relation to trauma. McNally (2010) states that one reason for the heated discussions around trauma is that trauma suggests roles of victim and perpetrator, which can be highly morally complex. For example, in the 1970s there were descriptions of veterans of Vietnam who were plagued by memories of their own horrific acts carried out on civilians. McNally notes that traditionally, these people would be considered perpetrators of trauma rather than victims, yet by ascribing responsibility to the State for sending these people to war, therapists were able to relate to the veterans as victims whilst not condoning their war-time behaviour (Fassin & Rechtman, cited in McNally, 2010). The notion that it is possible to become traumatised by one's own behaviour highlights the conceptual and moral complications that arise when attempting to make

sense of trauma (McNally, 2010, p. 389), and again highlights the inextricably socially situated nature of trauma.

To conclude, post-modernists state that trauma is not a ‘thing’ at all, but rather a historically located construct through which we have come to interpret suffering, and thus by using the term ‘trauma’ in an unreflective way, we mistake “the lens or frame through which we see things for the thing itself” (Lambek, 2009, p. 252). However, whilst it may be problematic to state that we can objectively define ‘trauma’, there are strong arguments for the importance of the concept of trauma to allow for the social recognition of the psychological implications of violence and oppression. Thus, the current research does not take a post-modernist position and dismiss the notion of trauma altogether. However, nor does the current research subscribe to an uncritical modernist approach to trauma, as defined by the concept of PTSD in DSM-IV. Rather this research argues for an *intersubjective* understanding of trauma. On this view, trauma is not defined by the event itself, but rather, what is traumatic is how a distressing experience is meaningful within a particular relational and socio-cultural context. Thus, trauma refers to the way in which an event is meaningful within an individuals’ intersubjective context (this includes both individual’s family and friends, as well as the wider social context) and previous traumatic or abusive experiences. These ideas, and the implications of an intersubjective conceptualisation of trauma, are developed further later in the review, and built upon throughout this thesis.

2.2.3 Research on therapeutic interventions with trauma

Research into the efficacy of different therapeutic approaches to working with trauma has primarily been based on trauma as conceptualised by PTSD, which, as I have argued, is a highly limited conceptualisation of trauma. Nevertheless, in what follows existing research will be briefly reviewed and then assessed. In addition, research on non-specific factors, including the therapeutic relationship, in therapeutic interventions with trauma will be discussed.

Seven meta-analytic studies indicate that trauma-focused interventions, namely eye movement desensitisation and reprocessing (EMDR) and trauma-focused CBT, are effective in reducing PTSD symptoms (Ehlers et al., 2010). This is understood to be because recovery from traumatic experiences requires exposure to, and processing of, traumatic memories, as well as consideration of the individual meanings of the traumatic event(s) (Briere & Scott, 2006). Some support has also been found for psychodynamic psychotherapy in reducing PTSD symptoms (Brom et al., 1989; Sherman, 1998), and American Psychological Association guidelines note that “[m]any clinicians currently believe that psychodynamic psychotherapy is better able to address the complications of complex trauma, especially with regard to interpersonal functioning, than cognitive and behavioural treatments” (Schottenbauer et al. 2008, p. 15). However, Ehlers et al. (2010) note that psychodynamic therapy and humanistic therapy for PTSD have been insufficiently studied to reach conclusions about their efficacy.

When interpreting research evidence, a number of theorists have argued that rather than fitting neatly into one diagnostic category, clients seen by therapists in the community are complex with varied responses to trauma, and so they argue that research trials can be unrepresentative (e.g. Chetoff, 1998; Schottenbauer et al., 2006). Indeed, the results

of a meta-analysis on studies of PTSD indicate that because of participant drop-out rates, sample screening and other factors, randomised clinical trials offer less guidance to practitioners than one would expect (Bradley et al., 2005). Schottenbauer et al. (2008) note that there are high non-response and drop-out rates for CBT and EMDR for PTSD in published studies, and that this may be because not all areas of distress are addressed by these approaches (particularly as regards ‘complex trauma’).

In their review of outcome research, Solomon and Johnson (2002) highlight the importance of non-specific factors to effective therapy with trauma, including establishing and maintaining trust and a good therapeutic relationship. In addition, research indicates that recovery from trauma can be an opportunity for growth that may include “new levels of psychological resilience, greater self knowledge and appreciation and increased empathy” (Briere & Scott, 2006, p. 68). This is an important perspective to hold when working with clients, in terms of valuing the human capacity for growth and development (Joseph, 2005). Further, some evidence indicates that the therapeutic alliance may be of even more importance to the therapeutic outcome in human-induced trauma (e.g. Cloitre et al., 2004). Certainly, for clients who have experienced extreme distress within a relationship, a different relational experience is considered to be highly valuable (Briere & Scott, 2006). However, whilst viewed to be central to therapeutic work, van der Kolk, McFarlane & Weisaeth (1996) state that the therapeutic relationship with trauma can be highly complex in terms of potentially replaying aspects of damaging interpersonal dynamics and involving intense, previously avoided emotions that may be almost intolerable for both client and therapist (p. xvi). This highlights the potential challenge to the therapists’ ‘use of self’ in therapy with trauma.

2.2.4 Theoretical conceptualisations of the role of the therapists' subjectivity in therapy with trauma

Within counselling psychology, the reflective use of self in therapy is listed as a core competency, and the therapists' appreciation of subjective and intersubjective factors is highly valued (BPS, 2006a). Indeed, Gelso and Hayes (2007) state that there has been an increasing focus on the therapist's subjectivity as a trans-theoretical concept. From a theoretical perspective, the Rogerian notion that in order to enter another's world without presupposition "[i]n some sense... means that you lay aside your self" (Rogers, 1980, p. 143), draws on the practice of phenomenology rooted in the philosophy of Edmund Husserl. This involves the attempt to bracket one's natural attitude in order to study phenomena in terms of their essence (Matthews, 2006). However, the validity of this transcendental phenomenology has been questioned; as we establish meaning by interacting with objects from the historical position we occupy, we are not transcendental subjects (Matthews, 2006). Indeed, later in his career, Rogers emphasised the value of therapists involving themselves in the relationship, whilst simultaneously maintaining an empathic stance (Gelso & Hayes, 2007). The recognition that the therapist's subjectivity is an inevitable component in the therapeutic process has led to a number of developments across the various therapeutic orientations (Wosket, 1999; Rowan & Jacobs, 2002).

Gelso and Hayes (2007) state that the therapist's subjectivity involves all the thoughts, images, feelings and physiological sensations that they experience, and that this inner world is of central importance to the therapeutic process in all modalities. In terms of the implications of therapists' subjective responses, a number of factors identified by the

American Psychological Associations' Division 29 Task Force on Empirically Supported Therapy Relationships (Norcross, 2002) as effective or promising elements of the therapeutic relationship are underpinned by the therapist's subjectivity, including empathy, congruence, the therapeutic alliance, the management of countertransference and resolving or repairing ruptures in the therapeutic alliance.

In terms of therapists' use of their subjectivity in therapy with clients who describe traumatic experiences, it is worth considering how this may be understood from different theoretical perspectives. What follows is not a comprehensive account of the different orientations' perspectives on working with trauma; it is recognised that within each orientation there are a number of divergent views, and within the limitations of this review it is not possible to do justice to the complexity within each position. Therefore this section provides a flavour of the literature from cognitive-behavioural, humanistic, psychodynamic, socio-political, existential-phenomenological and intersubjective-relational theories in terms of their relevance to the purpose of the current research.

2.2.4.1 Cognitive behavioural approaches

In their cognitive model of PTSD, Ehlers and Clark (2000, 2008) highlight the role of the person's appraisal of current threat, the nature of their memories of trauma, and the methods used to attempt to control their symptoms to the maintenance of PTSD. The therapeutic relationship in CBT is characterised by 'collaborative empiricism', the idea being that therapist and client work together as 'co-investigators' of the client's issues (Jackson et al., 2009). When the client is describing traumatic memories, the therapist's

role is to “guide” the client by helping to provide “structure and focus” to the narrative, as well as tracking the client’s emotional process and giving encouragement (ibid., p. 256). In this way “the therapist takes on the role of coregulator in the emotional experience that emerges from the creation of the narrative” (ibid.). Ehlers and Clarke (2000) note that there may be a challenge for therapists in this part of the work, as it involves asking clients to remember their traumatic experiences and face situations they currently avoid, and there may be a fear on the part of the clinician that doing this may mean the client’s symptoms deteriorate.

In cognitive approaches to therapy, which have traditionally placed less emphasis on the therapeutic relationship, there is a growing interest in relational issues (e.g. Gilbert & Leahy, 2007). In working with trauma, Sabin-Farrell and Turpin (2003) discuss the potential cognitive processes that could be involved in a therapist’s engagement with traumatic material: in cognitive theories, schemas colour how the world is perceived and experienced; new experiences either fit in with one’s schema and are assimilated, or the schema adapts to the new information and accommodation takes place (Piaget, 2000). In terms of therapeutic work with traumatic material, the therapist’s schemas may change in the process of accommodating new information (Sabin-Farrell & Turpin, 2003).

Indeed, the therapist may become more aware of the experiences of powerlessness, lack of safety and betrayals of trust that people can go through, resulting in changes in their schemas about the world (McCann & Pearlman, 1990). However, cognitive theories on these changes in schemas have not been developed in terms of how they might have an impact on therapeutic work.

2.2.4.2 Psychodynamic Approaches

In psychodynamic work with trauma, attention is paid not so much to traumatic experiences in themselves but to the way in which such experiences relate to childhood issues of conflict and distress (Garland, in Hemsley, 2010). In this view, if the child–caregiver relationship is insufficiently containing (i.e. if the caregiver is not able to respond to the child’s distress in a way that helps them make sense of and regulate their feelings), then the child will develop with a low capacity for regulating their affect and also limited reflective functioning. Thus, any therapy that does not address such early difficulties will only be able to help with some symptom reduction without addressing the underlying nature of the issue (Levy & Lemma, 2004). Containment is also viewed as pivotal to the therapy in order to support the client to re-examine and re-interpret the event, as well as face and mourn the losses involved (Garland, in Hemsley, 2010).

In psychodynamic therapy the relationship is seen as a ‘medium for communication’ (Levy & Lemma 2004). Indeed, in the psychodynamic literature, the role of the therapists’ countertransference has historically been very prominent. Lemma (2003) differentiates between the Freudian / ego psychologists’ and Kleinian / object-relational approaches to countertransference. Freudian / ego psychologists view countertransference as the therapists’ unresolved conflict-based response to the client. In this account, countertransference has no benefit to the therapeutic work and the therapist should monitor and further analyse their countertransferential responses to more objectively interpret the client’s unconscious communications. On the other hand, Kleinian and most object-relational approaches conceptualise countertransference as the therapist’s response to the client in its entirety, and views reflection on one’s

countertransference response as a valuable resource to assist in understanding the client, and how they relate to others, and to gain greater insight into aspects of themselves of which they may not be aware (Gelso & Hayes, 2002; Lemma, 2003).

In her discussion of countertransference responses to trauma, Dalenberg (2000) states that it is through the intensity of affect and the immediacy of emotions in therapy that the most powerful learning experiences are created. Indeed, some psychodynamic therapists emphasise the value of bearing pain with the client; that the therapist must ‘suffer’ the feeling in order for healing to take place (Gravell, 2010). Indeed, there is a consensus that it is more difficult to refrain from interpretation, which may provide a measure of distance, and to just *be* with the client (Gravell, 2010). On the other hand, Ogden (in Gravell, 2010) cautions, “the therapist must be sufficiently open to receive the patient’s projective identification and yet maintain sufficient psychological distance from the process to allow for effective analysis of the therapeutic interaction” (p. 33).

Dalenberg (2000) also highlights that if the therapist experiences themselves as threatened by the traumatic material, possibly because it relates to experiences in the biography of the therapist, then their countertransference response may be problematic. The therapist may become over-involved and focus too highly on the trauma (as in Wilson & Lindy’s (1994) conceptualisation of Type II countertransference response), or conversely to an unconscious evasion of the trauma, conveyed by minimisation and even disbelief (as in Wilson and Lindy’s (1994) Type I countertransference response).

Dalenberg (2000) notes that disbelief is a serious issue; it may be underpinned by the therapist’s defence against vicarious trauma, or their identification with the client’s uncertainty, or possibly their identification with society’s suspicion of victims. In terms

of dynamics in the therapeutic relationship when working with trauma, Dalenberg (2000) describes therapists potentially experiencing themselves in the position of the perpetrator when working with the recovery or working through of abusive memories, and feeling both guilt and shame for precipitating this difficult experience.

2.2.4.3 Humanistic Approaches

From a humanistic-existential perspective, trauma is seen as an existentially shocking transition, which can change or affect one's basic assumptions (Du Plock, 2010). At the same time, humanistic approaches highlight the potential opportunity for growth that is provided through traumatic experience (Joseph, 2005; Tedeschi & Calhoun, 1995; Mearns & Cooper, 2005). Joseph (2005) notes that it is through facing and working through difficulties that people may discover a sense of meaning and purpose in their lives, and then disasters and tragedies are viewed as the catalyst in creating a more satisfying and meaningful life. This is known as 'post-traumatic growth'. Tedeschi and Calhoun (1995) argue that it is vital that therapists have an appreciation of the value and importance of this way of viewing trauma; further, Joseph and Linley (2006) caution that therapists who are not aware of this or who do not work from this perspective are in danger of "thwarting the growth potential of their clients" (p. 1048).

Person-centred theory holds that with trauma there is a disintegration of self-structure and a loss of the ability to accurately symbolise experience in one's awareness (Joseph, 2005). In working with trauma, Joseph (2005) states that person-centred theorists acknowledge the importance of exposure; however, what is viewed as central to the

therapy is the process by which the therapist relates to the client in working on the exposure. Indeed, Thorne (cited in Hawkins, 2005) posits that people who have experienced abuse “desperately require the corrective experience of an affirming, deeply committed, non-abusive relationship in which they can find healing and discover hope for living” (p. 238). In this way the client will have the opportunity to regain the ability to symbolise their experience in awareness, bringing their self-concept into closer contact or integration with their organismic self (Joseph, 2005).

Working with trauma in this way is considered to place personal and existential demands on the therapist; Mearns and Cooper (2005) state that working relationally and ‘meeting’ the client within their traumatic experience will be highly distressing, and will have a long-lasting effect on the therapist. In staying alongside the client, the therapist will need to be able to reflect on their own experiences of loss, and be able to draw upon this in their work (Du Plock, 2010). Further, Thorne (in Hawkins, 2005) states that with some clients who have been very deeply wounded, providing a relationship of this nature may open up considerable distress or concerns about seduction; thus, attempting to work in this way requires immense faith in one’s own integrity. However, Gelso and Hayes (2007) note that from a humanistic perspective, the therapists’ subjectivity is generally considered trustworthy due to the emphasis on human motivation towards growth and well-being. This contrasts with the Freudian / ego psychoanalytic focus on the therapist’s subjectivity in terms of their countertransference as an impediment to therapeutic work.

2.2.4.4 Socio-political Perspectives

Herman (2001) attests that working in the field of trauma is inherently political because it highlights the situations of those people in our society who are oppressed. Indeed, Herman notes the difficulty of addressing systemic oppression in relation to sexual and domestic violence:

Widespread patterns of coercive control such as battering, stalking, sexual harassment, and acquaintance rape were not even named, let alone understood to be crimes, until they were defined by the feminist movement. Even the forms of violence that were nominally criminalised, such as sexual abuse of children, have been so rarely reported or prosecuted in the past that perpetrators were effectively guaranteed impunity. (p. 237)

Thus from Herman's perspective, one must firstly name and conceptualise as crimes various forms of violence in order to address them. De Zulueta (2006) takes a similar position, arguing that not only must violence be acknowledged by the victims but also by witnesses, especially because frequently perpetrators do not see their actions as violent or abusive. Further, De Zulueta argues that in order to recognise trauma, certain values must be upheld, including each human being's right to a certain level of freedom and a socially endorsed right to self-respect (2006, p. 4). Whilst this does not have implications for the therapist's subjectivity as such, it does highlight the central importance of the therapist's conceptualisation of trauma in therapeutic work from this perspective.

Herman (2001) also focuses on the importance of examining the meaning of the experience, not only for the client but also for the client's significant others (based on the understanding of the importance of the client's social context in their recovery and ongoing well-being). Herman states that this involves exploring issues of guilt and responsibility in terms of the traumatic experience. This is in order to generate a new understanding of morality and meaning to illuminate the client's experience and repair their sense of self-esteem, even in the midst of the undermining views of other people. In this task the moral position of the therapist is vitally important; for Herman, a non-judgmental stance is insufficient, rather the therapist must engage deeply and personally with these questions of meaning, not by giving answers, but by standing in "moral solidarity" with the client (p. 178).

In view of the challenge of "shar[ing] the burden of pain" (p. 7) with the client, Herman (2001) asserts that a dependable network of social support is necessary for the therapist, which must include a space where the therapist can communicate their emotional responses as well as practical issues relating to the work. In addition, Herman highlights the value of therapists becoming a part of social campaigns and movements for change as having the effect of increasing their capacity to retain a sense of hope in the face of terror and oppression.

2.2.4.5 Phenomenological-existential approaches

In his book 'Trauma: Culture, Meaning and Philosophy', Patrick Bracken (2002) highlights the way in which the prevailing tendency amongst psychologists is to locate

loss of meaning as an internal experience. However, Bracken draws on Heidegger to highlight that lived experience is embedded within a social, cultural and physical context. In this view, trauma is held to be comprehensible only within the individuals' social and cultural milieu, which means that to make sense of an incident for an individual or community, one must have an understanding of the social context prior to the incident (Bracken, 2001).

More broadly, in terms of contextualising the current increase of interest in trauma and PTSD, Bracken (2002) highlights the way in which the post-modern condition is characterised by “an undermining of meaning, order and coherence” (p. 102). For Bracken, such an understanding can make some sense of the contemporary focus on PTSD, which is centred around a collapse of meaning in the person's life. This does not mean that people living in non-Western cultures do not suffer following terrible events, but that the level of ‘ontological security’ in society has implications for the development of what Bracken (2002) terms ‘post-traumatic anxiety’:

In most Western societies there has been a move away from religious and other belief systems which offered individuals stable pathways through life, and meaningful frameworks with which to encounter suffering and death. During the same period the individual self, although more important than ever before, has been undermined by the very forces which assert this importance. For in the post-modern condition the self becomes the source of the meaning of the world while at the same time it becomes disconnected from that world. (p. 207)

Thus, Bracken argues for engaging with lived experience and socially embedded meanings as a guide to approaching trauma, and cautions against individualistic and technologising approaches which may be unhelpfully pathologising. Nevertheless, following Habermas' critique of Heidegger's totalising account of technology, Bracken maintains that it is not possible to simply forsake the technologies we have developed for addressing trauma. Rather, what we are called to think about is additional ways we may approach working with trauma, such as establishing healthy environments and re-establishing meaningful ways of life. Similarly, Herman (2001) also cautions that with the current advances in the biological research into trauma, there is an even greater threat to contextual approaches to trauma. Bracken (2002) offers what he terms a 'post-psychiatry' approach for working with trauma which centres on (1) a foregrounding of ethical issues; (2) a move towards contextualist understanding and practice; and (3) a recognition of power differentials.

2.2.4.6 Intersubjective and relational approaches

Relational and intersubjective approaches to trauma are often informed by attachment theory (e.g. De Zulueta, 2006; Brownescombe-Heller, 2010). On this view, our attachment needs involve an ongoing, lifelong reliance on significant others for self-esteem, stimulation and arousal regulation; as Kohut argued we are not self-encapsulated, fully self-reliant beings but have ongoing self-object needs (De Zulueta, 2006). Such needs render us susceptible to loss, deprivation and death. De Zulueta (2006) draws on Lindemann's definition of trauma as the "sudden, uncontrollable

disruption of affiliative bonds”, thus that “to deny the impact of trauma over human life is once again to deny that we matter to one another” (p. 185). Further, Stolorow (2007) develops the notion that trauma highlights “the unbearable embeddedness of being [in that it] exposes the inescapable contingency of existence on a universe that is random and unpredictable and in which no safety or continuity of being can be assured” (p. 16). On this view, trauma is a state of intolerable affect resulting from the failure of the intersubjective context to give the distress “a relational home in which it can be held” (Stolorow, 2007, p. 10).

The ability to find a ‘relational home’ for losses and traumatic events is held to be of vital developmental importance for the growing child’s resilience. Brownescombe-Heller (2010) articulates this in terms of the child’s capacity for reflective functioning, in that ideally the child learns that distressing events can be reflected upon, verbalised, and made into a narrative and handled appropriately in the future. Conversely, if attachment relationships are not ‘good enough’, or the child is neglected and their emotional pain is not met or is even negatively responded to, then the incident could be experienced as something “unknowable and unthinkable” (p. 656). In turn, the “capacity for empathy, reflective self-functioning and mentalization may be reduced” (ibid.).

In working therapeutically with trauma, a number of writers (e.g. Brownescombe-Heller, 2010; Cachia, 2010; Stolorow, 2007; De Zulueta, 2006) highlight the potential of the therapeutic context to reproduce the client’s traumatic experience. De Zulueta, (2006) argues that therapists may overly focus on intra-psychic processes to avoid their own painful feelings about the reality of trauma, with deleterious consequences for the client.

Central to therapeutic work from an intersubjective stance, therefore, is the client's experience of attunement, allowing previously unacknowledged emotional pain to find a 'relational home' (Stolorow, 2007). Creating a narrative for oneself and one's traumatic experiences is linked with increased 'reflective self-functioning' (the ability to reflect on our own states of mind and those of others), and also holds the possibility of building a greater sense of coherence, self-integration and resilience (Holmes, 1993).

De Zulueta (2006) notes how emotionally difficult it can be to work with trauma in that the therapist witnesses the pain of living without the illusion of invulnerability and is simultaneously made aware of their own reliance on such illusions. Further, whilst the therapist may aim to convey a high level of tolerance for powerful feelings, at times the therapist may experience painful emotions, and in response the client may, consciously or unconsciously refrain from sharing their full stories (Rasmussen, 2005).

In summary, there is a degree of convergence across the different therapeutic modalities that the reflective use of self is an important component of therapy in work with trauma. However, there are a wide range of theories about the ways in which the subjectivity of the therapist is implicated in therapy with trauma. Whilst the Freudian / ego psychoanalytic position emphasises the importance of the therapist working through their inner conflicts in order to prevent their countertransference contaminating the therapeutic work, the intersubjective perspective focuses on the therapist's mindfulness of the mutually influencing process of therapy where the therapist's responses both shape and are shaped by the therapeutic process. In addition, there are debates about how the therapist should ideally make use of their subjectivity. In the humanistic

tradition, for example, the therapist aims to draw on their own experience to empathically engage with the client, while psychodynamic theorists caution against letting one's history lead to over-involvement with the client. From existential-phenomenological and socio-political perspectives, on the other hand, there is a greater emphasis on locating traumatic experiences within the wider cultural context and addressing issues of power and values / morality within the therapy. What follows in the next section is a review of the empirical research on the subjective experience of therapists when working with trauma.

2.3 EXISTING RESEARCH ON THE THERAPIST'S SUBJECTIVITY WHEN WORKING WITH TRAUMA

The past two decades have seen a high level of research into therapists' responses to events classified as being potentially traumatic in DSM IV involving sexual or physical abuse, military combat, terrorism, mass violence and natural disasters and accidents (Zimmering et al., 2003). A growing body of literature suggests that therapists can develop a form of traumatisation variously termed compassion fatigue, secondary traumatic stress and vicarious trauma, involving intrusive and avoidant symptoms, physiological arousal, and feelings of helplessness and isolation (Sabin-Farrell & Turpin, 2003). Dalenberg (2000) notes that in terms of the criteria for PTSD, "learning about the trauma of a close associate could qualify as a trauma for the listener if the requisite emotional response occurs", and concludes that therapists working with trauma could fall into this category (p. 52).

Sabin-Farrell and Turpin's (2003) review notes that though symptoms associated with PTSD, burnout and general psychological distress have been found in relation to trauma work, correlations are generally low; and furthermore, findings are inconsistent, therefore they caution against the enthusiastic take-up of the concept of vicarious or secondary traumatising. Nevertheless, their review does reach the view that working with clients who describe traumatic events may elicit strong emotional, physical and behavioural responses in the therapist during therapy sessions. This suggests that therapists' use of their subjectivity may be more challenging in therapy with clients who describe traumatic experiences. What remains very under-explored is how therapists understand their subjective responses to traumatic material to impact on the therapeutic process, and whether such responses might help, hinder or be neutral in relation to the therapeutic process.

2.3.1 Quantitative research on therapists' responses to trauma

Research into the negative impact of working with clients who have experienced trauma involving one or more of sexual or physical abuse, experiences of military combat, terrorism, mass violence and natural disasters and accidents (Zimmering et al., 2003) employs two main terms for this phenomenon: compassion fatigue (CF), which is also known as secondary traumatic stress (STS), and vicarious trauma (VT). VT is believed to develop from exposure to traumatic material, empathic attunement with clients and feelings of responsibility for their well-being, and results in cognitive, affective and relational changes (Pearlman & Mac Ian, 1995). Compassion fatigue is held to be the

result of “knowing about a traumatizing event experienced or suffered by a person” (Figley, cited in Adams et al., 2006, p. 103), and empathising with those who experience pain and suffering, leading to lessened capacity and motivation to empathise with clients (Adams et al., 2006). Burnout has also been associated with trauma work (Sabin-Farrell & Turpin, 2003) and is characterised by a sense of emotional exhaustion, loss of idealism and feelings of reduced self-efficacy in relation to one’s work (Sprang et al., 2007).

More recently, positive findings about therapists’ responses to trauma work have led to the creation of concepts such as ‘vicarious post traumatic growth’ and ‘compassion satisfaction’, with some researchers (e.g. Arnold et al., 2005) arguing that these positive aspects need to be included in the conceptualisations. Compassion satisfaction (CS) is characterised by experiencing therapeutic work as an energising experience as well as having a strong sense of self-efficacy (Sprang et al., 2007).

Dalenberg (2000) states that physiological arousal and distress in listening to the pain of another person is common – indeed, it has been found that whilst skin conductance levels reduce in victims describing traumatic experiences, those listening become more aroused, and their skin conductance levels become raised (Pennebaker et al., 1989; Shortt & Pennebaker, 1992). In addition, findings indicate that working with a higher proportion of traumatised clients (Brady et al., 1999) and cumulative exposure to traumatic material (Schauben & Frazier, in Sabin-Farrell & Turpin, 2003) are also associated with elevated symptoms of PTSD in therapists. New and trainee therapists have been described as being particularly at risk of experiencing secondary traumatic stress symptoms in relation to their work (Adams & Riggs, 2008; Pearlman & Mac Ian,

1995). Neumann and Gamble (1995) describe Pearlman and Mac Ian's (unpublished) survey of nearly 200 trauma therapists, which found that newer therapists reported more intrusive imagery from the work as well as anxiety, depression and physical symptoms than did therapists with greater experience. This is consistent with research into the professional development of therapists, indicating that psychological distress is higher for therapists who are less experienced (Adams & Riggs, 2008; Hellman, et al., 1987; Rodolfa, et al., 1988).

In addition, higher levels of symptoms of PTSD and psychological distress have been found to be associated with certain types of trauma work, including working with greater numbers of clients who have experienced interpersonal violence and abuse, particularly involving children (Creamer & Liddle, 2005; Cunningham, 2003) as well as working in disaster response teams (Holtz et al., 2002). However, it is noteworthy that these studies were investigating the impact on mental health professionals in general, rather than therapists, and so these findings may be of less relevance. In terms of other work-place characteristics, the impact of training in this area remains largely unexplored (Sabin-Farrell & Turpin, 2003). Kassam-Adams (in Sabin-Farrell & Turpin, 2003) found that accessibility of support and supervision was not associated with PTSD symptoms. However, it may be that there are complications in terms of accessing support in that McCann and Pearlman (1990) reported that whilst trauma therapists were keen to share their experiences, they were worried about having a detrimental impact on their colleagues by disclosing details. In addition, Sexton (1999) notes that it may be difficult for therapists to share their feelings of vulnerability with co-workers due to feelings of shame.

Dalenberg (2000) cites research indicating that levels of childhood abuse and trauma are relatively high for mental health workers, ranging from 30 to 66 per cent (p. 237). A personal history of childhood trauma or abuse has also been found to be strongly associated with PTSD symptoms in therapists (Follette et al., 1994; Kassam-Adams, in Sabine-Farrell & Turpin, 2003), and experience of relational trauma has also been found to relate to higher levels of compassion fatigue (Jenkins & Baird, 2002). In their qualitative research, Steed and Downing (1998) reported therapists describing memories of personal experiences being brought up by trauma work as a negative consequence of working with trauma. Conversely, Schauben and Frazier (1995) did not find that symptoms relating to PTSD were significantly higher for therapists with a personal history of trauma. Sabin-Farrell and Turpin (2003) suggest that perhaps the discrepancy relates to the extent to which therapists have worked through their trauma; however, at present no research has explored this. Some trauma theorists have argued that therapists with a personal history of trauma may be at greater risk of over- or under-identifying with the client (Wilson & Lindy, 1994) and for potentially infringing upon client boundaries (Klutzn, in Dalenberg, 2000). At the same time there has been some research which indicates there may be positive aspects to therapists having had a personal trauma history, in terms of clients finding that it helped them to disclose and gave a sense of hope (Brabin & Berah, 1995), as well as viewing therapists as being more credible than those with no experience of trauma (Tedeschi & Calhoun, 1995).

2.3.2 Qualitative research on therapists' responses to trauma

In terms of qualitative research into therapists' experiences of working with trauma, Steed and Downing (1998) conducted semi-structured interviews with 12 female therapists working with sexual assault / abuse survivors and used thematic content analysis for the analysis. All therapists reported negative responses to their work, including frustration, shock, pain, anger, sadness and distress about traumatic imagery that they found overwhelming. Iliffe and Steed (2000) carried out semi-structured interviews with 18 therapists working in the field of domestic violence and analysed the interviews using interpretive phenomenological analysis. Participants described feeling horrified, angry, sad and nauseous during and after sessions, as well as experiencing visual imagery of violent incidents. Therapists also reported taking too much responsibility for clients, and finding it difficult to respect clients' choices (for example, to return to abusive relationships). Arnold et al. (2005) conducted "naturalistic" interviews with 21 psychotherapists who worked with clients who described traumatic experiences, and analysed the transcripts using Lincoln and Guba's constant comparative qualitative method. All 21 therapists reported negative responses to their work such as intrusive thoughts and images of clients' trauma, sadness, anger, fear, countertransference avoidance, and concerns over professional efficacy and physical exhaustion.

Danieli (1988) conducted open-ended interviews ranging from one hour to six hours with 61 therapists working with holocaust survivors. Content analysis was used to identify 'countertransference themes' from the interviews, which included rage, dread, shame, horror, grief, guilt and feeling overwhelmed by the intensity of these emotions. All therapists stated that their responses were unique to working with this client group.

Further, Danieli found that therapists used avoidance reactions in sessions such as forgetting, tuning off, avoiding asking questions of their clients, doing too much, identifying with the aggressor and focussing so exclusively on the holocaust that they neglected to see the client as a whole person. Danieli concluded that the inability to contain powerful reactions within themselves led to an inability to provide a holding environment in which clients could mourn their losses as part of the therapeutic process.

On the other hand, research has explored therapists' positive responses to trauma work. In Steed and Downing's (1998) qualitative study on VT, all participants reported that their work with trauma survivors had led to the experience of some positive personal outcomes. Many of the therapists interviewed described positive changes in their sense of identity and in their beliefs about themselves and others. In Arnold et al.'s (2005) interviews with psychotherapists about the personal impact of trauma work, all 21 described positive consequences of the work such as increased insight, tolerance, sensitivity, empathy and compassion, as well as a greater appreciation of human resilience (and for 16 participants, this was their first response to an open question about trauma work). These findings contrast with the overwhelming emphasis in the literature on the negative aspects of working with trauma. Descriptions of positive aspects of trauma work included positive changes in self-perception, interpersonal relationships and philosophy of life (all three major categories of post-traumatic growth outcomes identified by Calhoun and Tedeschi (cited in Arnold et al., 2005)). Arnold and colleagues (2005) conclude that the potential benefits of trauma work may be much more significant than the existing literature indicates. Joseph and Linley (2006) highlight that growth can be conceptualised as a component of the trauma response that can

coexist with distress. Notably, positive responses to trauma have not been explored in terms of their potential impact on the therapy.

It appears that, in all of these qualitative studies, therapists were not directly asked about the ways in which their subjective responses may have had an impact on the therapeutic process. Thus, despite the volume of research dedicated to examining the impact of working with trauma on the therapist, there is precious little research into the implications of the therapist's response to trauma on the therapy. Some researchers have discussed possible implications of compassion fatigue or secondary traumatic stress on therapists' abilities to demonstrate empathy (e.g. Wilson & Lindy, 1994). De Zulueta (VT) argues that in working with trauma, therapists empathically identify with their clients and recognise their own vulnerability in that "what has happened to these victims could so easily happen to those who attend to them" (p. 183). Similarly, Adams et al. (2006) argue that in order to protect themselves psychologically, trauma workers may avoid empathic engagement with their clients.

Pearlman and Mac Ian (1995) report that trauma therapists with greater experience demonstrate more disconnection from their inner experience and lower concern for others; they suggest that this may be a way of distancing themselves from the distressing pain of their clients. Arnold et al. (2005) note that several clinicians in their sample discussed responses that seem to reflect a struggle with "empathic strain" or difficulty in maintaining empathic attunement as identified by Wilson and Lindy (1994). Since empathy is conceived to be the vehicle through which vicarious trauma / compassion fatigue develops, it may be considered likely that therapists would lessen their empathic responding in the attempt to prevent personal distress. In other words, the experience of

distress in response to traumatised clients could lead the therapist to become emotionally distant, and impede their usual warmth and responsiveness towards clients (Adams & Riggs, 2008).

2.3.3 Implications of therapists' subjective responses for clinical practice

Neumann and Gamble (1995) conclude from their clinical experience that, if unaddressed, the implications of vicarious trauma can be highly problematic – ranging from the therapist disengaging from their clients, to ‘victim blaming’ and even violating therapeutic boundaries. Similarly, from her clinical observations, Herman (2001) notes that:

The therapist, like the patient, may defend against overwhelming feelings by withdrawal or by impulsive, intrusive action...this may include efforts to rescue or to control the client, denial or minimisation of the trauma, distancing or even crude abandoning of the client. (p. 151)

Indeed, the difficulty in listening to trauma may be the reason that therapists are reluctant to ask about a history of trauma in the first place (Briere & Zaidi, 1989).

Indeed, research conducted by Lothian and Read (2002) found that in a sample of clients using mental health services, though 64 per cent had experience of abuse, 78 per cent had not been asked about abuse history in their assessment.

Despite the persuasive power of these arguments, the notion that so-called secondary traumatic stress impairs therapists' empathic responsiveness or negatively impacts on

the therapeutic relationship has not been directly investigated. Interestingly, a dissertation investigating the impact of burnout on the therapeutic relationship actually found that therapists with higher levels of burnout were given greater ratings of rapport by their clients (Garner, 2006). These far from straightforward findings highlight the value of investigating the implications of therapists' responses to traumatic material on the therapeutic relationship.

2.3.4 Gaps and limitations in the current research literature

Shubs (2008) states that the literature on therapists' responses to trauma, including vicarious trauma, compassion fatigue and secondary traumatic stress, reflect an 'impediment' version of countertransference, in contrast to the conceptualisation of countertransference as a potential resource for therapists to guide their responses to the client. For example, Gampel (1998), working with a child survivor of the holocaust, described using her countertransference responses to attempt, with her client, to revive feelings and reconstruct gaps from her past; she stated that it was her countertransference response that informed her ability to do this. Thus, in relation to clients who have experienced trauma, there is value in further research that is open to exploring this perspective on countertransference.

Further, Rasmussen (2005) argues that a limitation of the research into vicarious trauma / compassion fatigue has been the "linear thrust of the investigations" (p. 22); most studies have attempted to measure the impact of providing trauma therapy on the therapist. However, based on intersubjectivity theory, Rasmussen (2005) conceptualises

therapy as an interaction in which client and therapist continuously influence and mould the responses of the other, both consciously and unconsciously. Intersubjectivity theories draw on continental philosophies that typically reject Cartesian dualism in asserting that “all of the experiences and meanings that constitute our lives are based in embodied engagement with the world” (Crossley, 1996, p. 28). Intersubjectivity, literally meaning ‘between subjects’, is an interdisciplinary field of study spanning many areas of psychology as well as neuroscience, social science and philosophy. In cognitive science, for example, the notion of the ‘embodied mind or ‘embodied thinking’ presents a parallel focal shift from a Cartesian to a Heideggerian account of being which rejects the dominant computer metaphor of information processing and presents cognition as an inextricably and inherently embodied and situated activity (Wrathall & Maplas, 2000; Anderson, 2003). Similarly, within psychoanalytic literature, a number of writers have discussed a shift from an emphasis on intrapsychic drives to a primary focus on relationality.

Stolorow (2007) states that drives are a product of the isolated Cartesian mind; in contrast, intersubjective psychoanalysis focuses on subjective emotional experience as regulated or misregulated within continuing relational systems. Indeed, Mitchell (1988) notes that we live in a “relational matrix”: “The person is comprehensible only within this tapestry of relationships, past and present” (p. 3). From an existential-phenomenological perspective, Merleau-Ponty (1958) argues that embodied experience and interaction with the world around us initially occurs pre-reflectively. Thus, to exist as a body-subject means being innately interactional in that human actions are

necessarily intertwined and interactive. In this way it can be said that we form an intersubjective system (Frie & Reis, 2001).

The implication of intersubjectivity theory requires a focal shift to research questions that explore the “reciprocal and dynamic interplay of subjectivities of therapist and client and the ways in which they interact to help or hinder the therapeutic process” (Rasmussen, 2005, p. 27), including the methodological and even philosophical challenges that such an approach may well entail. This approach highlights the fact that research that attempts to draw out universal countertransference themes in response to trauma entails that therapists’ responses are not necessarily seen in the context of a relationship that emerges and fluctuates over time. Thus, in terms of therapists’ responses to traumatic material, it is important to consider how a client’s disclosure is experienced within the particular and unique intersubjective context of an ongoing relationship.

2.4 CONCLUSIONS AND RATIONALE

Regardless of therapeutic orientation, the therapeutic use of self is recognised as being a vital aspect of therapy. This notion is supported by research that indicates that non-specific factors, underpinned by the therapist’s use of self, are a key aspect of therapeutic work with trauma. Empirical literature indicates that working with trauma has a negative psychological impact on the therapist, and prominent researchers have argued that therapists’ strong subjective responses to traumatic material have a detrimental impact on the therapeutic process. However, the notion that so-called

‘secondary traumatic stress’ impairs therapists’ empathic responsiveness, or negatively impacts on the therapeutic relationship, has not been directly investigated. In addition, research thus far has arguably been limited by the prevailing modernist conceptualisation of trauma as defined by DSM-IV. However, theoretical literature and research evidence highlights the inextricably social and contextual nature of trauma. This emphasises the impossibility of ‘fixing’ a definitive notion of what constitutes trauma, and the value of intersubjective approaches to trauma and to research on trauma. Therefore, informed by intersubjectivity theory, this research investigates the experiences of therapists working with clients who describe traumatic events, and how therapists consider their responses to the disclosure of traumatic material to impact upon the therapeutic process.

2.5 RESEARCH QUESTION AND AIMS

This research addresses the question: **‘How do counselling psychologists conceptualise their responses to descriptions of traumatic experiences to impact on the therapeutic process?’** Related to this primary question, the following areas of interest are explored: (1) How do counselling psychologists make sense of their subjective responses to working with trauma in their therapeutic relationships?; (2) In what ways, if any, do counselling psychologists view their subjective responses to impact on the therapy?; (3) What, if anything, has influenced / helped / hindered the way in which counselling psychologists work with their subjective responses to trauma in their therapeutic relationships?; (4) How do counselling psychologists view the way they work

with their subjective responses to trauma in therapeutic work to have changed / developed over time; and what, if anything, might have contributed to this?

Research into this topic may enrich our understanding of processes in therapy with trauma that help or hinder the therapeutic process, as well as potential obstacles to the effective therapeutic use of self, thus contributing to the research base on clinical work in therapy with trauma. It may also indicate training / support / other contextual factors that are implicated in the success, or otherwise, of the therapeutic use of self with trauma. The use of a phenomenological research method (i.e. interpretative phenomenological analysis) was chosen in order to allow an exploration of the research topic without the imposition of abstract theories and preconceived hypotheses. This choice will be fully examined in the following chapter, and the methodological implications for taking an intersubjective stance in the research will be considered.

3.0 CHAPTER TWO

3.1 METHODOLOGY

3.1.1 Overview

In this section, the rationale for selecting Interpretative Phenomenological Analysis as the research method is described, and the process of participant recruitment and the collection and analysis of data are outlined. Issues of reflexivity are discussed and further developed in the discussion section. Finally, the question of quality in qualitative research is considered and, again, this is revisited in the discussion section. In this section, I have elected to be flexible in my use of first person and third person writing styles; whilst the majority of the section is written in the third person, where this seemed stilted (for example in the reflexivity section) I decided to write in the first person.

3.1.2 Using a qualitative approach

Ponterotto (2005) states that research in counselling psychology has historically been predominantly from positivist and post-positivist theoretical frameworks with their associated quantitative methods. Broadly, from a positivist perspective, through the statistical analysis of numerical data derived from large samples, quantitative methods aim to discover universal laws of objective reality in order to explain and make predictions about this reality (Crotty, 1998, Ponterotto, 2005). Qualitative research, on the other hand, works with non-numerical data, such as interviews, and allows the researcher to engage with questions of meaning and to investigate how people make

sense of and experience the world (Willig, 2001). Morrow (2007) argues that qualitative methodologies are particularly promising for in-depth examinations of psychotherapy processes, and can “facilitate the theory building process” (p. 211). Existing research into therapists working with trauma is largely quantitative, perhaps because researchers have been trying to investigate questions such as whether or not vicarious trauma ‘exists’, how it can best be measured, and so on. However, in order to investigate how therapists experience their responses to traumatic material to impact on the therapy process, a qualitative approach is warranted.

Madhill et al. (2003) identify three broad epistemological positions within qualitative research; realist, contextual constructionist and radical constructionist. The researcher’s epistemological position (which necessarily drives the research process) can be described as situated between critical realist and contextual constructivist. On this view, which is particularly pertinent in human science research, it is not possible to reveal ‘objective reality’ by using the right research method – reality is necessarily interpreted, and perspectives towards reality are contextual (located in a particular time and place) and pluralistic (there are many different interpretations of reality) (Creswell & Miller, 2000; Madill et al., 2003). This means that research findings are contingent on the context of the collection of data and analysis, yet at the same time, there is an attempt to establish “some kind of grounding for results...through basing findings in participant’s actual descriptions” (Madill et al., 2003, p. 9).

3.1.3 Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) as a research method was developed in order to explore unique situations and lived experiences (Smith, 2006), and in particular how people make sense of their experiences (Smith, 2009). Thus, IPA is an idiographic approach concerned with detailed analysis of the particular, as opposed to a nomothetic approach, which pertains to the study of universal laws. As the proposed research is an in-depth exploration of therapists' subjective experiences in response to clients' descriptions of traumatic events, and how they understand and/or experience this to impact on the therapeutic process, IPA was considered an appropriate method. Indeed, Wertz (2005) argues for the value of phenomenological methods in terms of counselling psychology's interest in subjective, contextualised experience. Other methods were considered in the process of developing the research proposal, including grounded theory, discourse analysis and heuristics.

Grounded Theory: Grounded theory is a systematic generation of theory from data that has traditionally been located within a positivist paradigm; however, it has been argued that grounded theory can range from positivist to constructivist in its application (Charmaz, 2006). Since the area of research has already been highly theorised in terms of vicarious trauma, compassion fatigue, secondary traumatic distress and event countertransference, the researcher considered it more useful to explore participants' experiences using a phenomenological approach, rather than attempting to generate further theory.

Discourse Analysis: As the researcher is interested in participants' subjective (and embodied) experiences, discourse analysis, which focuses on participants' use of language as a cultural resource to achieve certain ends (e.g. Wetherell and Potter, 1988),

was also rejected in favour of IPA. IPA argues that people act not only as discursive agents, but also give meaning to their lived experiences (Smith et al., 2009).

Heuristics: Heuristic research, developed from phenomenological research by Clark Moustakas (1990), is particularly focussed on the role of the researcher in the research process, arguing that research flows from the researcher's inner meaning and awareness. For heuristic research, therefore, the researcher must have a personal connection with the subject of investigation. I wanted to reflect on my own clinical experience, but not make it the focus of the research project, particularly as I only have limited experience of working therapeutically with trauma, so I did not consider heuristics to be an appropriate research method.

3.1.3.1 IPA – a hermeneutic phenomenology

Smith et al. (2009) state that “IPA attempts to operationalise a hermeneutic phenomenology” (p. 201). Husserl's phenomenology controversially consisted of the attempt to ‘return to the things themselves’ through ‘bracketing’ one's preconceptions, the thing referring to the “experiential content of consciousness” (Smith et al. 2009, p. 12). Researchers using descriptive, Husserlian phenomenology attempt to reveal the essential meaning structures of a phenomenon. This approach is aligned with the realist, modernist notion that one can discover the universal properties of reality (Loewenthal, 2007). However, existential phenomenologists such as Heidegger, Merleau-Ponty and Sartre situate human beings as embodied subjects enmeshed in a world of objects, relationships, language and culture (Smith et al., 2009). On this view, phenomenology is

characterised as an inherently interpretative process. Hermeneutic philosophers (including Heidegger, Gadamer and Ricoeur) have posited an interpretative phenomenology whereby interpretation is an intrinsic aspect of our being-in-the-world: “without the phenomenology there would be nothing to interpret; without the hermeneutics the phenomenon would not be seen” (Smith et al., 2009, p. 37). In this account, rather than a faithful representation of participants' descriptions (a structural essentialisation), the researcher attempts to create a rich, contextualised and amplified ‘uncovering’ of a phenomenon (Hein & Austin, 2001). Hermeneutic phenomenology recognises that researchers are unable to set aside implicit preconceptions, but that the researcher must strive to become aware of them and make them more explicit (ibid.).

Smith et al. (2009) discuss Heidegger’s notion of ‘fore-structure’ (which comprises of the analyst’s preconceptions, assumptions and so on) as inevitably present and potentially obstructive to interpretation in terms of prioritising new phenomena. The same authors note that Gadamer’s notion of ‘foreprojection’ highlights that one may only become aware of one’s preconceptions once the interpretative process has begun, and that engagement with the phenomenon may then influence the interpretations, which may then influence the forestructure. In light of this, Gadamer asserts, “the important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meanings” (cited in Smith et al., 2009, p. 26). On this view, bracketing throughout the research process is never fully achievable; rather, there is a ‘dialogue’ between ourselves and the text and “it is through the confrontation with the other's otherness that our own assumptions and prejudices are thrown into relief and we gain new understandings” (Gadamer, in Finlay,

2009a, p. 12). In this way, ongoing attempts to become aware of one's preconceptions may best be viewed as a cyclical process (Smith, 2009).

In terms of the process of interpretation, Smith et al. (2009) discuss the central concept of the hermeneutic circle, whereby attempting to make sense of any given text involves examining its constituent parts, and to understand the parts involves examining the whole. For example, a word needs to be seen within the sentence to be properly appreciated, just as the sentence needs to be understood through a reading of the individual words. In this way the analytic process is 'iterative'. In relation to the researcher's preconceptions, this can also be viewed within the hermeneutic circle; "the 'whole' is the researcher's ongoing biography and the part is the encounter with a new participant" (Smith et al., 2009, p. 35).

Smith and Osborn (2003) describe the interpretative elements of IPA as a two-stage interpretation process; "the researcher is trying to make sense of the participants trying to make sense of their world" (p. 51). Smith (2004) encourages researcher *reflexivity*; this involves mindfulness on the part of the researcher of the ways in which their own position and perspective will inform their textual readings (e.g. Hedges, 2010). At the same time, the researcher, when reading a text such as an interview transcript, is asking questions about what is going on that may or may not be apparent to the participant themselves (Smith, 2004). In this way, IPA draws on Ricoeur's distinction between a hermeneutics of empathy and a hermeneutics of suspicion: a hermeneutics of empathy involves engaging with people's stories in a way that attempts to prioritise the participant's perspective at the heart of the narrative, whilst a hermeneutics of suspicion involves the researcher's attempt to make sense of the participant's story using

theoretical perspectives and ideas that are considered to shed light on the story in relation to the research question. By balancing the tensions between these two positions, Brocki and Wearden (2006) state that IPA reports “should be both sufficiently interpreted and contextualised” (p. 99).

3.1.3.2 Reflexivity

Brocki and Wearden (2006) argue that the interpretative nature of IPA has been given inconsistent attention in published IPA studies, and that it merits further consideration. Indeed, in view of the acknowledgement in IPA that we experience the world through our ‘forestructures’ and ‘foreconceptions’ (including assumptions and so on), it would seem essential to reflect explicitly on these factors throughout the research process (Yardley, 2000; Shaw, 2010). Reflexivity in qualitative research may involve a recognition of one’s perspective in terms of the research topic; discussing one’s research interest and experiences, motivations and theoretical positioning (Brocki & Wearden 2006; Yardley, 2000). However, Madill et al. (2003) state that such reflexivity can “be vulnerable to assuming an ‘uncomplicated subjectivity’... through expecting that both participants and researchers may articulate their position fully and neutrally” (p. 15). Nevertheless, the researcher considers it valuable to write a position statement, which, whilst neither ‘complete’ nor ‘uncomplicated’, is an attempt to offer the reader my identification of some of the factors that will be informing my perspective.

I am a 31-year-old white-British female of middle-class background and a counselling psychologist in training. My interest in the research topic began shortly after joining my

first supervision group as a counselling psychologist in training, when a colleague described the difficulty she had in working with a client who described some horrific events in detail. For a number of weeks my colleague was highly distressed within the supervision when she talked about her work with this client and I also felt shocked and saddened by what she described. This work culminated in my colleague deciding to leave the organisation, which meant ending quite abruptly with the client, and I was left feeling concerned both for the client and for my colleague. I wondered about the implications of the therapist's responses to such material for therapy practice. I also began to feel afraid of how shocking experiences that clients brought to therapy might impact on me, and whether I would be able to respond in a way that might be helpful to the client.

This experience sparked my interest in the impact of trauma work on the therapist, and more specifically what therapist responses might mean for the therapeutic relationship. I am relatively inexperienced in terms of working with trauma; however, during my training I have worked with some clients who have described traumatic experiences. Being with these clients as we talked about what had happened to them often led to intense feelings of anger and sadness, and I was sometimes unsure how to use these feelings in the session. I would usually note a sense of sadness being expressed in my voice, whilst I would attempt to 'bracket' my anger, and I've wondered about the helpfulness of this approach. In addition, whilst my training thus far has encouraged exploration of countertransference responses (particularly in terms of characteristic relational patterns), it seems that consideration of therapists' responses to traumatic material has been relatively neglected. Indeed, I have sometimes felt disappointed about

the lack of discussion about the ways in which traumatic material may be profoundly affecting, and how we might make sense of and work with these responses.

In addition, I have reflected upon difficult experiences in my own life, and my responses to these experiences, and how they may have impacted on my assumptions about the meaning of trauma, and perhaps might even have been an unconscious factor in awakening my interest in this research topic. It is therefore an ongoing process for me to be thoughtful about the ways my experiences inform my perspectives on the topic and I have kept a research journal to help with this (extracts are included in the appendices). Before carrying out any interviews, I conducted a self-interview with a colleague to become more aware of my forestructures. By answering my own interview questions in an open and honest way, I tried to ensure that I was aware of any personal assumptions or theories I might hold, and a summary document of my reflections on my interview is included in the research journal extracts in the appendices. However, I also acknowledge the limitations of reflexivity in the sense that from my theoretical perspective, it is never possible to fully 'know' oneself. However, by increasing my self-awareness I aimed to be as open as possible to what my participants described, rather than imposing my own ideas. This is different from the process of 'bracketing', where one tries to put *aside* one's assumptions. I did not include my interview material in the analysis as I do not fit the inclusion criteria (as a trainee), and this would be appropriate for a hermeneutic study, which I am not doing for the aforementioned reasons.

In terms of my theoretical position, I would describe myself as pluralistic / integrative, influenced by ideas from psychodynamic, humanistic-existential, cognitive and critical modality approaches. In addition, I do not see my theoretical ideas as being fully formed

or fixed but rather, I am ‘in dialogue’ with a number of approaches, and see this as an important aspect of my training. In terms of my perspective towards trauma, my position has changed in the course of carrying out this research project. Initially, I started with a more modernist approach to trauma; however, through my readings and the interviewing process I have become increasingly interested in intersubjective understandings of trauma and the way in which distressing experiences may be meaningful to an individual, or community, within a particular relational and socio-cultural context.

3.1.3.3 Intersubjectivity

Smith et al. (2009) note the intersubjective nature of Heidegger’s phenomenology, but the intersubjective process of carrying out an IPA research project has not been extensively discussed within the literature on IPA. Brocki and Wearden (2006) state that the researcher / interviewer’s contribution to the creation of the interview material remains unclear in IPA; to what extent does the researcher impact on the account “through active listening, prompting and encouraging further disclosure on selected topics” (p. 91)? Reid et al. (2005) note that semi-structured interviews are not a ‘neutral’ way to gain data in that the researcher collaborates with the participant to establish meanings and make sense of the topic under consideration. In terms of the present research as an intersubjective enterprise, it is understood that the research interviews are a co-constructed process in that both the researcher and participant are influencing what is discussed and how it is discussed: “what is revealed emerges out of a constantly evolving, negotiated, dynamic, co-created relational process to which both researcher

and participant co-researcher contribute” (Finlay, 2009a, p. 2). Further, the researcher’s interpretation of the interview transcripts will be shaped by ongoing discussion with the research supervisor, as well as peer researchers in the London IPA group. And in terms of the final written product, the subjectivity of the reader will be implicated in terms of further interpretations and understandings of the research topic.

3.1.4 Evaluating Quality

The use of quality and validity guidelines in qualitative research has been a subject of some debate. Hoyt and Bhati (2007) note the trend for many qualitative studies to follow guidelines more appropriate for quantitative research (such as trying to reduce researcher subjectivity) and in the process, risking that qualitative research will fail to realise its own potential in terms of providing “rich descriptions of individual experience and thoughtful reflections on the meanings of these experiences” (p. 209). Further, Brocki and Wearden (2006) highlight that qualitative researchers generally reject the notion that it would be possible or worthwhile to have a generalised set of guidelines for the use of qualitative methodologies. On the other hand, Elliott et al. (1999) state that whilst guidelines should not be a ‘check-list’, there is a need “for particular qualitative approaches to develop specialised guidelines that better express their particular interests” (p. 224). In terms of guidelines appropriate to IPA, Smith et al. (2009) recommend Yardley’s (2000) guidelines, and since they are compatible with the contextualist views of the researcher, they will be drawn upon to address quality issues in the present research.

Yardley (2000) describes four principal areas in terms of quality in qualitative research: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance.

Sensitivity to context. It is important to ensure as far as possible that the analysis is sensitive to the research context. This may include extensive familiarity with the theoretical and empirical literature connected to the research area, an appreciation of the wider contexts of the research participants (Smith et al., 2009) and sensitivity to the material provided by the participants. The researcher has engaged extensively with the research literature and has attempted to gain an appreciation of the contexts of the participants by being highly sensitive to this area in the research interviews. In order to address sensitivity to the material, the researcher has attempted to closely ground analysis in the empirical data as well as pro-actively seeking findings that go against the researcher's own ideas about the topic (Yardley, 2000). In addition, Yardley (2000) notes the issue of power dynamics between the researcher and research participants; whilst as a researcher it is difficult to overcome the power difference in terms of being the 'expert' and 'in control' of the project, nevertheless there is value in the researcher's ongoing awareness of this issue, and the consistent attempt was made by the researcher to remain mindful of this throughout the research process.

Commitment and rigour can involve extended immersion in the subject area as well as demonstrating competence and skill in the use of research methods. In terms of commitment, as well as extensive reading around the research area, the researcher attended a specialist conference on trauma run by the BPS, in order to engage with different approaches to the subject. *Rigour* relates to the 'thoroughness' of the data

collection and ‘depth and breadth’ of the analysis (p. 219); yet at the same time, Yardley (2000) has highlighted that “the intuition and imagination of the analyst can be much more important than any formalised analytic procedures” (p. 222). Smith et al. (2009) state that commitment and rigour may also be shown through one’s engagement with participants during data collection as well as during the analysis. While I had initially considered requesting feedback from the participants about my themes, I felt there might be a danger in this of giving away my own authority, under the guise of straining to be ‘democratic’ and to create a fully participative research process. In addition, the idea that the researcher would do this to gain validation for her account runs in opposition to the idea that this research is an interpretation – the *researcher’s* interpretation – of the participants’ experiences. Indeed, Finlay (2009b) argues that “[t]he practice of returning to participants to validate researchers’ analyses...could be disputed as a problematic throwback to empirical, realist ideals” (p. 17); that is, that there does exist some kind of ‘objective truth’, and returning to the participants might somehow increase one’s chances of discovering it.

In line with my epistemological position, it therefore seemed more appropriate to use different sources of feedback to improve the quality and richness of the analysis. I therefore attempted to achieve this through research supervision, and also through presenting the research at a specialist group for IPA research, where group members looked at selected quotations from my themes and described their understanding(s) of them. I used this to help gauge the credibility of my analysis, and to develop the richness of my own interpretations. Further, my supervisor carried out an audit of my analysis of one of the interviews. Finally, a peer-researcher conducted an initial analysis of one of

the transcripts, which we then discussed in relation to my analysis. As I am interested in intersubjective meanings, discussing my ideas throughout the process of analysis was a valuable way of developing the quality and richness of my interpretations. An audit trail of the process of analysis is included in the appendices.

Transparency and coherence. The written report can be assessed for transparency and coherence in terms of the clarity with which the stages of the research project are described, as well as the coherence and persuasiveness of the argument that is advanced. The rhetorical persuasiveness of the report is especially important in research such as IPA, where the interpretative role of the researcher is highlighted (Yardley, 2000). The researcher deliberately attempted to attend to this issue throughout the writing of the report, as well as using her research supervision to help with it. In addition, Smith et al. (2009) suggest that an ‘audit trail’ may enhance the transparency of analysis as well as its credibility. As previously mentioned, an audit trail is included (see Appendices 7–9), with a transcribed interview with initial comments and emerging themes, initial list of themes and table of themes for one interview. A reflective journal was used throughout the research process in order to chart the progress of my developing ideas, as well as to aid with the quality of my analysis. A sample from the journal is included in Appendix 10.

Impact and importance. Finally, ‘impact and importance’ relate to the idea that, however well designed and implemented, the project also needs to be considered to be relevant and useful (Smith et al. 2009) and this issue is taken up in the discussion section.

3.2 METHOD

3.2.1 Participants

Smith (2004) notes that IPA is highly idiographic; the IPA researcher begins with the analysis of one case, and only when the exploration has reached a point of satiety does the researcher move on to the next case. Smith (2004) goes so far as to value the ‘idiographic logic’ for conducting an IPA analysis for a single case in order ‘to do the case justice’. Indeed, Smith et al. (2009) caution that larger volumes of interview material may inhibit quality of analysis (which requires time, reflection and dialogue). Smith et al. (2009) recommend conducting between four and ten interviews for a doctoral research project. I wanted to strike an appropriate balance between gaining sufficient data to ensure salient similarities and differences between accounts could be explored, on the one hand, and on the other, not gaining so much data that the quality and depth of analysis were compromised. In the event, by analysing the interview transcripts as I progressed, I was able to gauge the point at which I felt I had sufficient material and that a credible pattern was discernible across the accounts. This point was reached after conducting interviews with nine participants.

In order that areas of convergence and divergence can be explored in detail, a relatively homogeneous sample is required; therefore participants were recruited for the study from the Division of Counselling Psychology. Since counselling psychology is broadly underpinned by a humanistic value base, and the therapists’ appreciation of subjective and intersubjective factors is highly valued (BPS, 2006), it was anticipated that this would generate a level of homogeneity of perspective across the participants’ accounts,

such that variation within this could be explored in detail. Initially I considered recruiting both trainee and qualified practitioners in order to explore accounts of practitioners with a breadth of experience. However, on conducting a pilot interview with a trainee counselling psychologist, it became clear that much of the material related directly to specific training issues. As the training process was not of direct relevance to the present study, I decided to recruit only qualified counselling psychologists.

Advertisements for participation were circulated via the BPS Division of Counselling Psychology email list. I also contacted participants directly through the BPS Division of Counselling Psychology practitioner database, using ‘interest in trauma’ as my search criterion. I also sent my advertisement to colleagues and supervisors working in trauma settings, to pass on to qualified counselling psychologists. In addition, I recruited one participant through the ‘Approaching Trauma’ training day run by the BPS Division of Counselling Psychology. Participants were required to have experience of working with clients who had experienced trauma, usually involving one or more of the following: sexual or physical abuse, experiences of military combat, terrorism, mass violence and natural disasters and accidents (Zimmering et al., 2003).

3.2.2 Procedure and analysis

Semi-structured interviews of approximately one hour duration were carried out in order to explore participants’ understandings of their responses to descriptions of traumatic events, and how their responses impact on the therapeutic process. Smith and Osborn (2003) argue that semi-structured interviews are generally the most successful way to

collect data, as the researcher's questions can be reconsidered and adapted through engaging with participant's ideas, and the researcher can spontaneously respond to interesting ideas that come up. Interviews took place at locations of mutual convenience. The interview schedule (see Appendix 6) consisted of approximately eight questions that focussed on participants' experiences of trauma work and the therapeutic process. The schedule was used flexibly in order to reflect areas that participants regarded as being important; and with regard to the controversies surrounding trauma as a concept, the interviewer attempted to remain open to ways in which participants conceptualised trauma. Interviews were tape-recorded and transcribed verbatim.

For the analysis, the steps identified by Smith (2004) for IPA were used as guidelines. After an initial reading of the transcript, an overall summary impression was noted. Then the transcript was re-read; this time notes and reflections were made in the left-hand column of the transcript. On a third reading, themes were identified and noted in the right-hand column. These themes were created into a table of constituent themes based on the notations in the right-hand column, and then checked against the participant's words to ensure they were grounded in his or her own account. At times I found the initial notes in the left-hand column to summarise a theme more successfully than the right-hand 'theme', which could be rather abstract. Smith et al. (1999) state that the table of themes should "capture most strongly the respondent's concerns on this particular topic" (p. 223), so I used this as a criterion to judge what I selected as constituent themes. The constituent themes were then clustered together, and those themes that appeared to the researcher to be central to the participant's experience were labelled as master themes. These master themes were checked against the original transcript to

reflect on how they operated in the participant's account as a whole. In terms of the master list, themes were selected for their 'richness' and their ability to "illuminate other aspects of the account" (Smith et al., 1999, p. 226).

Another table containing these master themes and constituent themes was created; this became the basis for a development of the interpretation of the themes. The same process was carried out for all the transcripts. It was important that each transcript was approached with mindfulness about the ways in which reflections from the previous analyses may have been influencing the researcher's current perspective (Smith et al., 2009), and the researcher used her research supervision to address this. Following the analysis of all transcripts, areas of convergence and divergence between cases were explored in detail. This involved forming a 'picture board' of connected themes for the group as a whole, and a final table of super-ordinate themes, together with their constituent themes (Smith et al., 2009).

To determine the prevalence of a theme, and thus the representativeness of subthemes and superordinate themes for the group as a whole, the researcher drew on the criteria provided by Smith (2011). Firstly, the subtheme needed to be represented across a sufficient number of participants' accounts; usually at least half. That is, the theme needed to be engaged with in a meaningful way by at least half of the participants. In a sample of nine participants, the bar was therefore set at a minimum of four participants for each subtheme. In selecting extracts to support the theme, a minimum of three extracts from different participants were chosen, though usually more than this were selected in order to demonstrate the convergence and divergence within the theme (Smith, 2011). Extracts were selected on the basis of what the researcher judged to be

most representative of a particular theme, and also extracts that provided the richest interpretative capacity to demonstrate both the variation and depth of the theme. A table showing the superordinate themes, subthemes, prevalence of themes and numbers and sources of extracts is provided in Appendix 11 and this also demonstrates the proportionality of sampling (i.e. that extracts were drawn from all of the participants across the different themes).

Analysis is an iterative process (Smith et al., 1999); once the analysis is ‘complete’ and the process of writing up has begun, further interpretations may be made, which will involve returning to the transcripts. Throughout the interviewing process and analysis stages, a reflective diary was consistently kept to help with reflexivity, for example explicitly noting and reflecting upon when and why interview questions had changed. It is important to note that despite the clarity of this procedure, the IPA approach also involves a “healthy flexibility” (Smith et al., 2009, p. 79) in order to allow a certain level of creativity, intuition and innovation in terms of the analytic process.

3.3 ETHICS

Ethical approval for the study was sought from the researcher’s university ethics committee. A consent form and information sheet about the research were given to the participants, to read and complete, and these included information about how data would be used, and steps to maintain confidentiality. At the beginning of each interview, the participants were reminded verbally about confidentiality and their right to withdraw at any time, but that if they withdrew once the project had already been written up, the

researcher retained the right to use aggregate data from the study. In addition, the researcher was aware that because of the potential for semi-structured interviews to be highly personal and intimate, it was possible that participants would express more than they intended to, and possibly more than is in their best interest (Morrow, 2007; King, 1997). The researcher therefore reminded participants at the beginning of the interview that they did not need to answer all questions, and that as far as possible it was up to them to ensure that they only expressed what they were comfortable with.

Participants were given the opportunity to ask questions both before and after the interview, and after the interview participants were debriefed. Debriefing forms included ID numbers for each participant in the event that they wished to withdraw. All names and identifying details from the interviews were changed for transcription. Participants were offered access to completed transcripts to ensure exclusion of identifying details and accuracy. Both recordings and transcripts will be destroyed once the requisite ten-year retention period has elapsed.

The research was conducted in line with BPS Code of Ethics and Conduct (2006b) standards of protection of research participants, and aimed as far as possible to treat research participants in a way that did not compromise their well-being. Additionally, in line with the principle of beneficence (BPS, 2006b), the following points were observed: (1) if exploration of the subject matter were to lead to apparent distress to any participant, the interview could be ended by researcher or participant with no pressure or expectation to continue; (2) a list of agencies that provided confidential support was provided at the debriefing stage; (3) if the interview were to lead to a participant's concerns about clinical practice with clients, the participant would be asked to contact

their supervisor and / or line manager as was most appropriate; and (4) to protect participant confidentiality, the researcher would make no attempt at contacting the participant in any other contexts.

Risks taken into consideration were the possibility that a participant would disclose something about their practice that is in breach of BPS (2006b) ethical guidelines, or which constituted a legal breach. At this point the researcher would consider her responsibility under BPS ethical guidelines to report this by discussing the issue with the research supervisor and the BPS ethics department, and follow appropriate guidance. This was communicated to participants on the information sheet so that they could consider this before they agreed to take part in the research project. It was also highlighted to participants on the information sheet that taking part in an interview on the subject of trauma had the potential to be emotionally provocative, and it was recommended that they give this due consideration before agreeing to participate. The researcher also considered this issue whilst formulating the research project in terms of her own well-being when conducting interviews. With regard to issues of safety for conducting interviews off-campus, locations were selected that did not pose a risk to participants (such as their own home). In addition, an arrangement was made so the director of studies could be informed of the timings of the interviews to ensure researcher safety.

4.0 CHAPTER THREE

4.1 RESULTS

4.1.1 Overview

Interpretative phenomenological analysis (IPA) of the nine interviews resulted in the identification of four superordinate themes with twelve subthemes. The superordinate themes were:

- **Demands and challenges in the use of self in response to trauma**
- **Dimensions of complexity in working with trauma: Conceptual, contextual, ethical, political**
- **Developing the therapeutic self in response to trauma**
- **Valuing the therapeutic self in work with trauma**

An exploration of these superordinate themes with their constituent subthemes (see Table 1) forms the basis of this section of the thesis. This interpretive phenomenological analysis is one account of the therapeutic impact of counselling psychologists' responses to clients' traumatic experiences for this particular group of counselling psychologists; it is recognised that different researchers might have focussed on different areas of the participant's experiences. Further, the analysis does not cover all aspects of the participants' accounts, and focuses on material that is relevant to the research question.

Verbatim quotes are included in order to illustrate the themes, and minor amendments have been made for ease of reading. Deleted words are indicated by dotted lines between brackets (...), and where words have been added to indicate what a participant

is referring to, this is presented within square brackets. Dots prior to, or after, an extract mean the participant was talking before or after the quoted extract. All identifying information has been eliminated or disguised to ensure anonymity and confidentiality, as discussed in the method section.

Table 1: Superordinate and Subthemes

Superordinate themes	Subthemes
Demands and challenges in the use of self in response to trauma	<p>‘It’s just horrific’: The difficulty of bearing the pain of trauma</p> <p>Stepping in or stepping out?: Dilemmas in working with own emotional responses</p> <p>Negotiating complex interpersonal dynamics</p>
Dimensions of complexity in working with trauma: Conceptual, contextual, ethical, political	<p>Grappling with unstable conceptualisations of trauma</p> <p>Grappling with trauma in context</p> <p>Grappling with moral and ethical dimensions of trauma</p>
Developing the therapeutic self in response to trauma	<p>‘Somehow you have to go through hell and back’: Changes to the self through working with trauma</p> <p>Learning from others</p> <p>‘You have to find a way to resolve that in yourself’: Reaching a place of acceptance and hope</p>

Valuing the therapeutic self in work with trauma	<p>‘I was just being with him, to be honest’: Valuing personal qualities in work with trauma</p> <p>‘Making sure you know where you’re at’: Valuing self-awareness in work with trauma</p> <p>‘Its about psychologically keeping yourself safe’: Valuing self-care in work with trauma</p>
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4.2 DEMANDS AND CHALLENGES IN THE USE OF SELF IN RESPONSE TO TRAUMA

There were a number of struggles that the participants described in terms of their use of self in response to traumatic material. All the participants described the difficulty of bearing the pain and horror aroused in them, and for some participants this was experienced as being traumatised themselves in response to their work with clients. In addition, participants grappled with the extent to which they ‘stepped in’ or ‘stepped out’ of the pain being expressed, and also what they communicated to their clients about their own responses. Participants also described grappling with complex and challenging dynamics within the therapeutic relationship.

4.2.1 ‘Its just horrific’: The impact of witnessing the pain of trauma

All the participants described the difficulty of experiencing painful emotions in response to particular traumatic stories. When Beth conveyed some particularly sadistic details of abuse, she noted that feelings of horror are inevitable in response to this:

You can't help but think, d'you know, what a bastard – or kind of that's horrific, and have those feelings of – how can I put it – of kind of horror.

This conveys the difficulty of putting such feelings into words; the words 'kind of' suggest that 'horror' is the best approximation but perhaps doesn't, and never could, capture the actual experience. Nadia said:

A lot of what people tell me about is things that happened to them when they were children and it makes me angry sometimes, or it's just horrific and you just think it unimaginable, d'you know what I mean? Particularly if you've got children of your own as well.

Indeed, five of the participants described the way in which, when they shared biographical experiences with the client (such as having children), there was a greater emotional impact when listening to their experiences. In addition, all participants expressed their sense of the emotionally demanding nature of working with trauma. On hearing horrifying details of abuse, Beth repeats twice "how can somebody do that to somebody else", conveying a sense of incredulity about what she hears, and perhaps not wanting to believe the extent of human cruelty. Beth (like a number of participants) described a process of 'traumatisation' that she experienced in her work:

I don't know if you've heard of vicarious trauma before – yeah – but if you kind of are soaking up other people's stuff, what you're doing is you're walking around enmeshing your feelings with their feelings – you don't know whose belongs to what, and you can be traumatised by it.

Here Beth conveys a sense of a sponge-like nature of being. When working with trauma she depicts a process of absorbing what is communicated, and that her feelings and the client's become intertwined so that there is confusion about whose feelings she is experiencing. Similarly, Lydia describes a confusing physical synchronicity between herself and a client:

My mouth was also going very dry, which is interesting – she said she had a dry mouth and wanted to drink – she was actually frothing at the mouth – so whether that was related or just down to my own anxiety [...] she just wanted to regurgitate all of this trauma that she'd witnessed over quite a long period of time, including the deaths of mum, dad, multiple siblings by a satanic ritual.

In this extract there is a sense of the trauma as difficult to take in – as something highly indigestible, and at the same time of experiencing physical sensations and wondering how to make sense of this. In a similar vein, Elisa described working with a client who had experienced extensive traumatic and abusive experiences in childhood, and the changes Elisa noticed in herself:

I noticed that actually I was more distressed myself or I was having – I was beginning to think more about what she said outside of sessions, and even beginning to – I don't think I had dreams, but there were certain images of sexual abuse going on for me.

Elisa mentions a number of times her fear about the nature of the communication in therapy; in relation to the images of sexual abuse, she later added that it was like “going through some dissociation or something just because I'd been with her”. This conveys

the difficulty of trying to make sense of this experience, and Elisa noted the helpfulness of coming across the literature on vicarious trauma:

Yeah, that's what I imagined it was – this communication that's so right-side of the brain instead of just left side – you know the logical way I'm telling you – its just different than that. And I assume that's why – you start using the right side of the brain yourself – I think you need to – you have to, but I think that's one of the pitfalls.

This conveys the challenge of trying to understand this complex interpersonal process; with the words “I assume that's why”, there is a sense of something happening to the self that is almost an alien process, and which even requires the invoking of neurological theory to understand. Elisa contrasts this with a logical conversation, which is conscious and controlled, unlike this perhaps dangerously unmediated communication. In describing her experience of what she identified as vicarious trauma, Beth tells me about a horrific story, and states that she was then unable to “drop” the image and found herself becoming distrustful of people in general. She links this to working in a prison setting and a breakdown in the usual sense of boundaries between offenders and non-offenders:

When you're not in the prison environment, as you know, you don't think about things like that, and when you are in a prison environment, you realise this is your next-door neighbour, this is your Dad, this is your brother, this is the man down the street. And you start looking out for things.

In this there is a sense of loss – loss of the illusion of separateness or ‘otherness’ of those who carry out acts of violence and abuse. In response to this, Beth described “starting to look out for things or read into things or be mistrustful of people” – for her, the world and other people became a potential threat that must be watched out for, and she stated that she viewed this as “contamination”.

For Timothy, listening to the re-telling of a story of a bayonet attack was particularly difficult, in that it appeared that the veteran “was actually doing it again the way he reacted emotionally”. This conveys the way in which there was a re-experiencing or re-living element to witnessing the clients’ story. For Timothy, like Beth, the difficulty in hearing a traumatic account was in his own imagination:

I think it was again the shock of when he’s saying these things to me – I would get in my own imagination and version of it, and I suppose it’s what comes from that. Cos you’ve talked now quite graphically about killing someone, and not just killing someone but he said that he describes his emotional state as angry. He went up there with anger.

As well as the shock, Timothy went on to say how difficult it was “to imagine how you (...) [could] do these things to someone else – another person”. Again, as for Beth there is a sense, perhaps, of the difficulty of accepting what humans are capable of doing.

4.2.2 Intersubjectivity reflection

The following material is included here as it relates to the participants’ descriptions of

‘contamination’. The intention is to convey a flavour of my reflections on intersubjective processes in the interviews. Initially in the interviews, I was trying to understand the experiences that participants described as ‘contaminating’ from an ‘outsider’ perspective. However, when one of the participants described, in detail, a story that she had felt traumatised by, I felt a sudden nausea and a sense of disorientation, or perhaps dissociation – I certainly felt somewhat removed from what was happening. Though the intensity of this feeling did not last for a long time, I had a lingering feeling of sadness, and what I can perhaps best describe as a sense of detached coldness in how I experienced the world. This gave me a visceral sense of what might be meant by the word ‘contamination’ that participants described. Following this experience I felt a greater empathic resonance in my responses to participants’ experiences, and I sensed this may have been conveyed to participants through my tone of voice and facial expressions. At the same time I was mindful of the dangers of over-identification and assuming a shared understanding, and I provide further reflection on this in the discussion section.

4.2.3 Stepping in or Stepping Out?: Dilemmas in working with own emotional responses

Participants took up different positions in terms of their approach to ‘using’ their emotional responses in working with trauma. Eight of the participants expressed their view that experiencing intense responses to traumatic material in the therapy was potentially anti-therapeutic. Participants conveyed the sense that strong emotions

interfered in the therapy and prevented them carrying out technical interventions effectively. For example, Rachel questioned the efficacy of the therapist to be able to work therapeutically if they have a strong internal response:

You have to get to a point where you can't get washed away by them. It's almost like, yes, this person's having a really big response, but if you had exactly the same big response, can you actually get on and do the work?

Here, the words “washed away” convey a sense of the potential tidal-wave-like impact of the client's emotions, threatening to obliterate the self. Similarly, Lydia questioned her ability to “do the work” when experiencing a strong internal response – which she described as “struggling”:

If the client had picked up that I was struggling at that point, it may be then that they lose confidence in the process and the fact that as a therapist I'm trying to contain their distress.

Lydia's extract conveys her sense that the client may need the therapist to be relatively emotionally unaffected in order to feel confident in the therapeutic process. Further, Lydia later expressed her concern that her emotional responses could potentially interfere technically in her use of EMDR, which could be “quite damaging”. In terms of responding to trauma, Michail conveyed that getting into a panic has the detrimental impact of closing off the therapist's capacity for thinking:

...we need to retain our ability to think, and that's one of the things that gets shut off with traumatic experience – you can't think, you just panic....

In Timothy's account, being "prepared" for therapeutic work involved being focussed on the client's needs, and putting his own feelings to one side:

... it hit me (...) so I put it to one side – I'll come back to it later when I'm in a better place – a better position to work with it – when I'm on my own. I can work with it on my own, but at the moment I've got to stay with this woman 'cos she needs it.

Here, Timothy expresses his need to work with his emotional reactions separately to the therapy in order to "stay with this woman", thus his emotional responses are experienced as bringing him *away* from his emotional connection with her. Similarly, Lucy talks about the importance of being able to step outside her powerful emotions in the therapy when there is a danger of being paralysed or overwhelmed by fear.

I think that was one of the occasions that I realised that inside myself, I have to be able to step outside of this if I want to do anything about it (...) because I think fear can be so overwhelming and disabling, really.

Lucy also talked about the danger of communicating her internal responses when working with trauma:

...the healers really have the capacity to harm even more than the original perpetrators do, I'm very careful of giving them feedback on my feelings (...). The idea that [the client] could contaminate somebody else would break her really, so for me the reflective part becomes very small in trauma work, and the holding part very big.

Here it seems that Lucy is describing her efforts to protect the client from the awareness of the impact of their experiences on her feelings, and that rather than sharing her feelings, she tries to provide a “holding” space for the client’s feelings.

On the other hand, a number of participants argued for the therapeutic value of emotionally resonating with the client’s experience. For example, Serra described her emotional immediacy when listening to a particular trauma narrative:

...she started talking and she was getting emotional, and I started getting emotional with her – and even thinking about it now I get emotional (...). And, yes, for some people it might seem very unprofessional, and I hold my hands up, it’s unprofessional, but I think at some point when she was going through her story we both started crying.

Here, Serra conveys an expectation that her response will be viewed as unprofessional – that joining the client in crying is something to hold her hands up to. So there is a sense of an internal division between the ‘professional self’ and the ‘unprofessional’, perhaps more human self, who experiences emotion. Yet paradoxically, the phrase “I hold my hands up” also conveys a sense of ownership or acknowledgement about what she did, and that she chooses to identify with her ‘unprofessional’ self in her therapeutic work. Serra went on to describe her sense that through sharing another’s pain, *both* talker and listener gain “some sort of comfort in that huge grief”. Despite stating that she thought it would be viewed as unprofessional, Serra clearly valued the sharing of suffering, and spoke of emotional resonance as an embodied act:

...step into her grief (...) that gives the person the permission whose mentioning it to not run away from it but stay with it as well. And then they realise actually, they have the emotional power, they have the emotional mechanisms not be destroyed by this pain.

The idea of stepping in to the client's pain stands in diametric opposition to Lucy's idea of stepping out. Serra presents this embodied stepping into pain as being central to her therapeutic work to enable the client to survive their emotional pain. Similarly, Elisa states:

...one has to be prepared to get in there with them and feel some of what they're feeling so that they can communicate it.

The words "get in there" suggest an embodied, intentional act of moving into an emotional space with the client, in order to enable their feelings to be communicated. Michail also emphasised the importance of the therapist having an emotional response to a client's traumatic narrative:

... it's important to be touched by the experience – I do not think that being there as a dead face in response to a traumatic account is useful at all. Because if you're not seen to be touched by the experience, then you become an onlooker. And of course with traumatic events, especially if they're sexual – with traumatic events, part of the trauma is that there are onlookers who refuse to intervene.

In this account, not only is it important to be emotionally responsive, but the therapist should be "*seen* to be touched". Michail argues that the importance of the therapist being

emotionally moved is a way of providing a different experience to the original trauma where onlookers remained untouched and did nothing.

Beth communicated a conflicted perspective on the therapeutic implications of communicating her internal response. Initially, when discussing her feelings of horror in response to a client's traumatic story, Beth stated "you don't show that to the client, obviously"; however, she later described the value of sharing something of her inner response:

...it was that acknowledgement that, yeah, that was horrific, and why wouldn't you be upset about it or why wouldn't you be in the state you are?

Here Beth presents a dilemma that runs through many of the accounts: On the one hand strong emotions are viewed as somewhat unprofessional; indeed, the words "you don't show that to the client obviously" suggests that there is an accepted therapeutic convention against this. On the other hand, therapeutic responsiveness is viewed as potentially valuable to therapeutic work in providing acknowledgement that the clients' response to a horrific event is understandable.

4.2.4 Negotiating complex interpersonal dynamics

Seven of the participants described challenging dynamics in their relationships with clients who had experienced traumatic events. For example, when working with a client who came in bruised from a violent relationship, Elisa felt a strong sense of responsibility for this, to the extent that she felt she had betrayed her client:

I felt absolutely terrible – as though I’d totally betrayed her by allowing it to happen – as though this was down to me [*laughs*]. And I remember apologising to her and saying “I’m sorry this has happened”. (...) I did want to protect her and make sure she wasn’t abused – ‘cos she’s a vulnerable adult without any shadow of a doubt.

Here, Elisa initially questions her feeling of responsibility saying “as though this was down to me” with gentle irony, and laughs at this. Moments later, however, she states that her client is a “vulnerable adult”, conveying a duty – perhaps even an ethical duty that she take a certain amount of responsibility in relation to her. Beth also described her protective feelings towards her client in working with trauma:

I was wanting to fix her, if that makes sense – I was wanting to make it all alright, and obviously that impacts on the relationship, and on the therapy that you’re giving rather than walking along-side somebody....

Beth later described thinking about “what I wasn’t doing or what I was doing”, somehow scrutinising her own performance as though if only she could provide better therapy, perhaps she could “make it all right”. Beth acknowledged the impact this might have on therapy, and that there were implications for the power dynamic in therapy – that rather than walking along-side, she was trying to “fix” her client.

Lucy describes a different relationship dynamic:

...[the client] was very bitter and very full of hate, and she projected that all on to me and it left me – I feel so shaken I could barely speak in the session (...)

There was almost no way of comforting this woman, or even of holding her, she was just there on her own, spewing fire.

In this example Lucy experiences herself as an object for emotions to be projected on to – the notion of the client being “on her own” highlights the absence of interpersonal connectedness.

Other interpersonal difficulties described included experiencing the self being drawn in to the relationship in non-therapeutic ways. Serra described being challenged by a relationship dynamic relating to a client’s childhood where being abused was associated with being special:

...it was as if she was, with her, it never felt the talking was that therapeutic, it just felt like – a bit of a test – a bit of manipulation – it never felt like somebody (...) with this person, there was some sort of – some lack of something – it was very difficult....

The notably tentative, uncertain language here seems to convey the highly complex nature of this interaction. What appeared to be most problematic for Serra was that something was happening but was not made sense of in the therapeutic communication. Elisa described her sense of concern about discussing her client’s sexuality, which was also striking in its complexity:

I think [it was] probably to do with this communication, that’s not all at the verbal level, and how exposing that would be of me and my own sexual inclination, and how crossed over that could get, possibly. And how it might cross over with transference-type feelings and, you know, is she going to say she

loves me and that kind of stuff? (...) so maybe that's because of that fantasy that I had – that you're not quite sure where you finish and they start, so it feels a bit too unboundaried a topic to get into.

Here there is a sense of danger about getting into an “unboundaried topic”, which is linked to Elisa's fear of what might be unintentionally communicated at the non-verbal level. There is a concern that communicating about sexuality might elicit the client's disclosure of loving feelings through the unintentional exposure of her own sexual inclination. As in Serra's description, there is a sense here of the murkiness around trying to make sense of dynamics which Elisa summarises as a fuzziness about “where you finish and they start”. As a result, Elisa delineated clear boundaries in terms of the areas she is prepared to explore in therapy.

Michail described that on two occasions his presence as a male “served as a trigger”. In one example, he described what happened after he observed to a female client that she had kept her handbag on her lap throughout the whole eight months of therapy:

... she very graciously removed it and she put it on the floor and she gets this massive flashback, stands up and can't stand facing me and ends up hiding behind a curtain. And my experience was, oh my god – I think I was traumatised – I was afraid. (...) I served as a trigger, and of course that's a risk that we all take if we work with traumatised persons

This example conveys a sense of a power dynamic being played out in an entirely unintended way; that Michail's position as therapist in noting the position of the handbag was perhaps interpreted as a request to move it. Michail here communicates his

sense of shock and trauma about the impact he had on the client, and his sense that there is a continuous risk when working with trauma of unwittingly provoking a trauma-related response.

On the other hand, Timothy noted that as a male therapist working with a female client with a history of violent and abusive relationships with men, there was an opportunity to provide a new kind of experience:

...working with a male therapist I think she was a bit unsure at first. But I think (...) she trusted me, and maybe that's helped her see men in a different light.

Similarly, Serra described that the potential of the therapeutic relationship to offer the possibility of trust is of vital importance with trauma "...because when you're that traumatised, it's quite difficult to rebuild your trust in people". Indeed, this relational component is of central importance to Serra in terms of her professional identity as a counselling psychologist, where "the most important thing for us is the relationship".

However, it is notable that when reflecting on how trauma is manifested in the therapy relationship, Michail stated that "it's difficult to think of a pattern because it's so individual". This challenges the idea that it is possible to make any generalisations about the interpersonal dynamics in the therapeutic relationship with people who have experienced trauma, and indeed, there is considerable variety in the experiences that participants described, as set out above. This is explored further in the discussion.

4.3 DIMENSIONS OF COMPLEXITY IN WORKING WITH TRAUMA: CONCEPTUAL, CONTEXTUAL, ETHICAL, POLITICAL

Participants discussed grappling with a confusing array of differing and at times incompatible understandings of trauma. There was a strong sense in the participants' accounts of the efforts made to consider the contextual basis of traumatic material in terms of the client's life, as well as, for some, the wider social context. In addition, a strong theme for some participants was the significance of establishing a moral / political position in relation to traumatic events described.

4.3.1 Grappling with unstable conceptualisations of trauma

Five participants discussed a distinction between 'type one' or 'simple' trauma and 'type two' or 'complex' trauma. For example Serra stated:

...trauma in itself is very, very wide itself – it goes from a very complex, very repeated trauma to a one-off.

A number of participants drew on the concept of a trauma continuum with a one-off incident experienced as an adult at one end, and at the other, repeated traumatic experiences originating in childhood, which some participants linked with the diagnosis of borderline personality disorder. In all of the participant's accounts, the way in which trauma was conceptualised, and the distinctions between different types of trauma, had clear implications for the therapist's way of working. Michail described this:

If it's a straight post-traumatic stress disorder, what is called post-traumatic stress disorder, when you have sudden onset, one serious life event, then I tend to

find that solution-focused or cognitive work lends itself better. It's very much managing flashbacks or managing anxiety....

This suggests that 'type one' or 'simple' trauma can be worked with in a relatively straight-forward way – that there is clarity about what it is and how to manage it. This is held in stark contrast with the more complex accounts of working with 'type two' trauma. For example, Lydia stated working with complex trauma:

...would feel a lot more like I'm feeling my way round in the dark (...) for clients who have been given the label of borderline personality disorder, because their backgrounds have been so chaotic and the current environment is so chaotic, I suppose the end goal I have in my mind, or what we decided at the time, changes.

Here working with complex trauma, which Lydia links with borderline personality disorder, requires a more intuiting approach, where the end goal is not clearly visible but must be felt out.

Elisa explains her belief that therapy with people with experiences of childhood abuse needs to be long term:

I think maybe its long-term work – one has to be prepared to get in there with them and feel some of what they're feeling so that they can communicate it. And I sort of go with this neurological belief that their communication is different because the abuse actually affected their neurological development.

In this extract, Elisa conveys her sense that long-term work is necessary in order for the therapist to experience the client's feelings, and in this way enable them to communicate. The words "I sort of go with this neurological belief" indicates a lack of certainty about her position, though it is unclear whether this is because Elisa is uncertain about the biological account or whether it indicates that she also "goes with" other understandings. At any rate, there is a strong sense of grappling for an understanding that makes sense of what is experienced as a drastically different way of communicating. For some participants, the notion of trauma was further complicated, and the simple / complex trauma model did not sufficiently account for traumatic experiences that their clients presented. For example, Elisa conveyed that so-called 'simple' trauma is not so simple:

[A single traumatic event] can progress to a sort of general anxiety syndrome or adjustment disorder or a more specific phobia, so people are describing flashbacks or lots of loss of confidence and not being able to get back to who they were....

The idea of "not being able to get back to who they were" indicates the potential identity changes that can follow on from the experience of a 'simple' traumatic event. Michail lists a number of issues that can be related to trauma:

You have things like relational anxiety or fear of abandonment or chronic lack of self-care, identification with the aggressor – I don't know, I'm not sure – but they're more subtle symptoms that can more easily be labelled as depression, or

anxiety disorder or alcoholism – one of these ‘isms’, and the underlying trauma’s not addressed, and I think that’s a shame, really.

In this account Michail highlights the danger of not addressing the “subtle symptoms” in terms of providing therapy. Yet at the same time Michail presented the challenge of arriving at *any* conceptual understanding of trauma, as it is so difficult to make any generalisations about what trauma is, and how one can work with it:

I’m not sure if there’s a specific pattern I can present. I think that’s difficult to think of a pattern because it’s so individual – there are so many ways people can be traumatised, and we are so creative in inflicting torture on each other – I’m still surprised with the stories I hear.

In contrast to these accounts, Rachel described a conceptualisation of trauma in more objective terms:

I think because I worked [with trauma for] about ten years you get to kind of have a feel what traumas tend to respond and how they respond...

Here, Rachel conveys that through experience she has learned that particular traumas respond in relatively predictable ways to therapeutic interventions; thus, there is a sense of trauma being more clearly defined and predictably treatable in Rachel’s account.

4.3.2 Grappling with trauma in context

Six of the participants spoke about the importance of appreciating a traumatic experience within the context of the individual client’s life. Beth conveyed her sense that

trauma is defined by the individual's experience and that this means that as a therapist, one needs to follow the way in which the client defines and experiences any particular event:

... her father had died and during the counselling she revealed that she'd been sexually abused by somebody who was now dead, and I thought, oh my god, this must be a big deal. So I automatically thought we need to work on this – but actually she was fine with it (...) [she'd] put it into her own context.

Here, Beth argues for the value of not making assumptions, and following the client's experience and understanding of what is traumatic and what they need. Similarly, Serra highlighted that for her:

The nature of the person, their resilience and resources, the context (...) and also what their hopes and dreams are (...) I think that what we therapists do in each situation is shape our experience, shape our therapeutic interventions according to all this variation.

In this example there is a sense of therapeutic interventions as necessarily fluid and responsive in order to be able to engage with the experience and needs of a particular client. Similarly, Elisa highlighted the different emotional meanings that bringing traumatic experiences to therapy can have:

He felt he was weak – he'd cry – it took weeks for us to get to a point where he could cry here and not feel terrible about it.

In this example, Elisa conveys that rather than working directly with the traumatic experience, she needed to address the client's feelings about what it meant to bring this experience to therapy. Beth extended the notion of the importance of viewing traumatic experiences within the context of the person's life, to include the individual's wider social context:

... you hear, actually, I've not told my husband because they wouldn't understand – I've not told my wife because they wouldn't understand.

Here, part of what Beth describes as traumatic is the lack of understanding within the client's relational context following traumatic experiences. Beth gave another example of the importance of recognising the client's wider social context when she described a poignant moment, when she acknowledged that her client's disability was implicated in her traumatic experiences:

I said to her, I have a real feeling that your disability is kind of entangled in all of this, and that's some of the reasons that people have abused you – and she just broke down. (...) she said you're the first person who's treated me like a human being and not gone around the houses, and not pretended I've not got a disability...

Here Beth conveys a sense of her humanising recognition of difference in this account.

Lucy, who trained as a counselling psychologist in a country where "you had to be prepared to work with murders and rapes sort of, on a daily basis" highlighted that for her, the very nature of what is traumatic is contingent on the social context:

...when I came to the UK, I'll be honest I was a bit shocked about the things people go to a psychologist for (...). But you quickly learn that that is just as traumatic for that person as the daily trauma in [country of origin] is to those people, so it's just a perception idea. And then developing the empathy for that, that so now I'm almost, I'm almost a bit soft in working with trauma.

Here Lucy highlights the importance of recognising the cultural differences in what is experienced as traumatic and, in relation to this, her need to recalibrate her own emotional responses. Lucy further articulated the importance of recognising the implications of trauma in terms of social roles, through her descriptions of the significance of the use of language:

...you don't speak about rape victims – [you speak about] survivors of rape, so there's also a political correctness in the way you express it. But I like the underlying psychological meaning attached to it, (...) just a different way of phrasing it already makes them listen differently to you or view themselves differently.

In this example Lucy presents herself as counteracting unhelpful attitudes to trauma, and argues that the thoughtful use of language has an important part to play in the success of therapy, particularly in terms of the client's relationship with themselves. Michail extends this idea to the notion of the importance of healing at a social level, as well as within individual therapy:

... with victims of abuse – therapy is useful but it's also useful when the person gets a prison sentence, [when] there's some visible sign that their suffering is

recognised. I think we need to think of the social aspect of trauma – the larger relational context in which trauma happens – [or] is allowed to happen.

This radically locates trauma within a wider social context where the traumatic experience is “allowed to happen”, and the notion of a “visible sign” communicates the importance of the social recognition of trauma. Michail also speaks of the importance of language in considering issues of responsibility:

I don't like the abuser / perpetrator language – [it] freaks me out in itself (...) because it locates the abuse in one individual, and I have hardly ever met a case where the abuser is one individual and its not a collection of people who close a blind eye – decide not to be curious, fail in their responsibility...

In contrast to the participants who emphasised the importance of contextualising traumatic experience, Rachel noted:

I might terminate therapy early if I can see the person's not responding to therapy, I'll be honest and say I can see that I'm not quite sure why, but your particular brain is not perhaps responding to the EMDR or CBT techniques, and I think it's going to be kind of not effective to continue, and I will call it a day. I will be honest, if there is no improvement.

This conveys Rachel's conceptualisation of trauma and recovery as primarily biological processes. However, like many of the participants, Rachel's account contains more than one position in relation to trauma, as she later discussed her interest in the role of people's belief systems in recovery from trauma:

She said that she hadn't gone to one of the Ancestor Festivals, the year after her gran had died, and she felt really bad. And so we explored what would that ceremony look like, and what would you have done and how would you be involved? How could you do it again?

In this account, the particular meaning of the trauma for the client is presented as being of vital importance in understanding her distress and in the healing process, which contrasts with Rachel's biological stance as presented earlier.

4.3.3 Grappling with moral and ethical dimensions of trauma

Four of the participants discussed issues of ethics and morality in relation to working with trauma. Timothy and Rachel both argued for the value of holding a position of moral neutrality. Rachel, speaking about working in a context of civil unrest and conflict in her country of origin, stated:

It doesn't matter which side of the war you're on, people come out seriously hurt. And it was interesting. I don't know, I felt almost like you stayed politically neutral. It doesn't matter who you've got in front of you. It's just a human being, and you have to get the human being well again.

Here it appears that Rachel prizes her perspective on the commonality of human distress, emphasising her role as a healing role. She stresses that there is value in separating oneself as a practitioner from the wider social context and political meanings to allow this to happen (without avoiding the fact that she has a "side"). Timothy described

taking a similar position in working with both ‘victims’ and ‘perpetrators’ of abuse/trauma:

... it’s one of the things that happens for whatever reason that later on, they become people that do it themselves. (...) So I suppose it’s just me accepting that these people I’m working with – this is what’s going to happen, and rather than giving people labels, treating them as individuals...

Here it appears that the notion that it is inevitable that those who have been abused go on to abuse others aids Timothy in “treating them as individuals”, which like Rachel allows him to identify with a healing role; as he later says, to see “how I can help them”.

A number of participants felt that working through moral dilemmas raised issues that they grappled with in a complex way. In contrast to Timothy, Beth experienced conflicting thoughts and feelings in working with people who have been abused and then go on to abuse others:

... they blame the fact that they’ve been abused for the reason why they’re abusers. But actually there are millions of people out there who’ve been abused and don’t go on to abuse themselves, does that make sense? So it’s no excuse really.

Here Beth conveys her difficulty in working with people who she senses don’t take responsibility for their actions, arguing that having been abused is “no excuse”.

However, moments later Beth stated:

... you have to put their offence to one side and just concentrate on their trauma, themselves and how that's affected them and how you can work with that (...)
we had to work within coming to accept the crime he'd done in order for us to, if you like, lower the PTSD symptoms and everything.

There is a sense of the effort it takes for Beth to try to put their offence aside and focus on the trauma and not wanting to collude with the violent act and yet wanting to provide a context of healing acceptance. Here Beth conveys the idea that accepting the crime is therapeutically healing, and therefore that this is something she "had" to do as a counselling psychologist.

Michail described taking a different position, and highlighting the danger of treating clients in an apolitical, decontextualised way:

...I have had clients that have been through tremendous abuse and they were medicated for years, they received all sorts of treatment, and nobody bothered to ask, in this case the female, is it safe to go home, are you beaten, why would you like to kill yourself?

Here, the client is presented as a being treated in an overly medicalised way, by a thoughtless mental health system, which does not consider the wider context and therefore leaves the 'real' problem untreated. In contrast, when he found himself acting as a 'stressor' as a male therapist, Michail described that:

... what helped was that I allowed the client to have control of proximity – so I offered the therapy – I offered to continue seeing her, but I didn't require her to come. And we discussed very frankly whether she could tolerate a one-hour

session, or whether we'd need to shorten the session for a while, and that's what we did.

Here there is a sense of Michail being very keen to come to a collaborative arrangement with the client, and in this way offering her some power and control in terms of the process of the therapy. Michail went on to expand this idea in terms of arguing for the importance of highlighting the operating of power relations:

I'm very interested as well about power relations – how would this person think it's OK to lash out in that way, or talk to you in that way? – how's that organised in the family or in the system?

This can be seen as therapeutic in a very different way to that described by the therapists above in terms of encouraging reflection on trauma within a context of power, offering the client the opportunity to (re)consider their position within their social context.

Michail recounted a client's end of therapy evaluation:

...she told me that what really helped me is I think you became – you were angry about it. The way I read it is that she realised I wasn't a passive by-stander – I wasn't in collusion with the perpetrator (...). And I think as therapists we can't risk being there – we can't be morally neutral or blank screens at that point. It's dangerous.

Here Michail conveys a sense that we are all implicated in systems that permit abuse / oppression, and that one has a moral obligation to take an active stance against this – for to be passive is to be collusive and, in his view, dangerous to the client.

4.4 DEVELOPING THE THERAPEUTIC SELF IN RESPONSE TO TRAUMA

Participants conveyed the way in which their therapeutic selves were developed over time, through formative training and therapeutic experiences. This was presented as a challenging journey, with significant changes for some in terms of their sense of self and/or the world. Participants communicated a sense of development in terms of their ability to respond therapeutically to traumatic material, and this was brought about by reaching a point of some acceptance.

4.4.1 ‘Somehow you have to go through hell and back’: Changes to the self through working with trauma

All participants discussed changes to the self through their training and their experiences working with trauma. These changes were described as being most dramatic at the beginning of their work with trauma – often in a training context. For both Lucy and Rachel who trained in their country of origin, training was viewed as a particularly difficult stage in professional development, but a necessary one in terms of developing a hardy self that could cope with trauma. Rachel described “a massive desensitisation programme”, as preparation for the horrors of trauma and a moment when she made a conscious decision that she was going to do this work:

I remember sobbing my heart out in the first lecture and hanging on to a guy (...) and we both sat there crying our hearts out – going, don't worry it will be OK, and I'm going no, it's not OK. It's terrible. And then we both decided we tough,

because you can't act – because they were basically saying, if you can't do this, we really recommend you go and find a new career.

Rachel later stated that the words “we tough” related to the experience of growing up with two brothers and not wanting to be second best. There is a sense here of Rachel identifying with the ‘tough’ part of herself, as the self she needs to be, in what seems to be a formative moment in the development of her professional identity. Rachel also describes a process of development through the teaching on her training:

Somehow you have to go through hell and back with them, and are you willing to go to hell and back? (...) I noticed that [by] the end of the programme, what we were taught was, to actually have that inner strength (...) I could sit and listen to any trauma, and I just... The difference was really massive. I like – I wouldn't feel like I wanted to cry. I wouldn't feel like I couldn't cope.

Again, here what is emphasised is the notion of willingness “to go to hell and back”, but also a gaining of inner strength and a confidence in her ability to cope. Similarly, Lucy, who trained in the same country, described being systematically exposed to traumas including the satanic abuse of children:

Olivia: And it sounds like the training experience in general was something quite shocking? Quite difficult?

Lucy: Yes it was. It was. I think it was quite necessary – we needed to be able to work with all sorts – with everything – because there's such a shortage of skills, you really had to be hands on and be able to deal with everything. At the same time, it did do secondary trauma, no doubt.

Here, this exposure is perceived as both damaging and necessary in order to be able to work with the prevalence and variety of trauma. Lucy also discussed the identity shift she experienced in this work:

Yes – you get a bit like a paramedic or a fireman who sees so much of it that the only way to cope with it is to become humorous about it in a very black-humour sort of way, and you start to only associate with people who share that viewpoint.

There is a parallel here with Rachel's account in terms of Lucy's development of a tough self to "cope with it", and Lucy conveys that this shift goes beyond professional identity to impact on other aspects of the self, such as who she associates with. Conversely, Serra described her development in terms of a "softening" rather than a hardening process:

... not running away from it, softening into it and allowing emotions to happen. Possibly that's what I've learned through experience. Possibly, when I started I wasn't that comfortable with emotions and was a bit unsure, and possibly at times I was trying to control too much.

Serra presents her early attempts to control the therapeutic process as a result of her discomfort with emotions, and through experience she feels better able to allow her emotions "to happen". Here, rather than experiencing herself as more inoculated from traumatic stories over time like Lucy and Rachel, Serra feels a greater capacity to emotionally engage with them. Nadia also described the difficulty of being exposed to people's traumatic stories when she first started working with trauma:

I think when I first started in this kind of work, everything that everybody said completely shocked me because it was another world.

The notion of it being “another world” indicates the vast difference between her sense of self and her known world, and the experiences that the clients described. Nadia also valued her training and stated that her psychodynamic training was particularly important so that:

...you don't hit parts of yourself that are a huge shock, or if they are, it's interesting rather than, like, life-threatening in some way. It's not, like 'oh my god, what's happening to me?' – it's like, 'wow, what's that about?' (...) you actually go away and think about it.

Nadia highlights that from her initial shocked response, the training allowed her to become more open to different parts of herself. Thus, through the training, rather than internal experiences being an intense, potentially obliterating threat to the self, they are interesting to reflect upon.

Beth described the way in which her responses have developed through both training and experience:

I think I don't soak up so much (...) I've been able to improve on my bracketing and improve on distancing, improve on empathy rather than sympathy, and improve on ... yeah, just being with the client but not being contaminated by it.

Here, Beth names the development of a number of therapeutic skills that allow her to be present with the client without being “contaminated”. Similarly, Lucy described ongoing efforts to balance an empathic connection without being “damaged”, noting that “sometimes being too much of a container can be damaging to the therapist”. Lucy also highlighted the importance of experience in developing her responses to trauma:

I think a lot of it was born out of need, because we did have all this trauma to deal with as trainees, and didn't really have the tools to deal with it. So you develop a framework for yourself to help you cope with it, because if you just try to go by the book, that's not enough. And I think then, when you get a positive result, you start to build on some of the techniques – start to build confidence....

Lucy emphasises her desire to bring her “gut feel” and creativity into her work, but also the necessity of developing her own framework to “cope” because theory – “the book” – is experienced as insufficient. In this account, her confidence is hard won through experience.

4.4.2 Learning from others

In all of the participants' accounts there were a number of ways in which peers and supervisors were involved in the development of participants' use of self when working with traumatic material. Lydia emphasises the vital role of supervision to “stick with” difficult therapy processes:

Fortunately I've had supervisors that have helped me stick with it and see it through – this is what you started with – and particularly my current EMDR supervisor, if it wasn't for having him to check in with between sessions, I'd probably be in a complete pickle. So that would have been a hindering fact – I would have been too cautious in benefiting my client in the long run.

In terms of developing her responses, Lydia suggests that supervision both helps by containing her anxiety and also developing technical aspects of her work. Timothy also emphasised the value of learning from supervisors:

... a big part of my learning's been with people who have supervised me and made me realise that I can do it – that I have got this ability of picking things up from people and working in the right way with people (...) and there's a natural course rather than trying to force something.

Here, Timothy indicates that his supervisors' belief in him has developed his belief in his own ability so that he can 'let go' rather than forcing the therapeutic process.

Serra highlighted that the development of her emotional strength to work with trauma was gained through experience:

I think you need to have a level of emotional strength to deal with it. That doesn't come with training – that comes more with experience and learning from others' experiences – successful therapists and through supervision.

Michail also described negotiating his emotional responses over time and the role of supervision within this:

...some of the stories I hear provoke very intense anger or very intense hate. But it's not useful to tell the client 'god, I wish your father was run over by a truck', or something (...) So that needs to be managed somehow (...) it's managed through supervision, and it's managed because I guess eventually you become a bit more confident that you can manage.

Here, Michail highlights the value for him of supervision and experience in being able to manage intense emotions without them being communicated or leaking into the therapy in an unhelpful way. Rachel's supervisor also had an important role in her development – because of her experience of working in an environment that was so violent, she described her supervisor's observing that:

...[I was] most probably, dissociated from the emotional response, in order to stay strong. So, she said, right, could you bring the human back a bit? And it took some years, and I said to her, fair enough, but at the same time still being able to feel not flooded by the information.

Thus, in Rachel's account there is a sense of negotiation in terms of being “human” in one's emotional responsiveness and yet still maintaining some distance in order not to feel “flooded”. In this way there is a sense of an ever-present threat of her self becoming overwhelmed by traumatic material, and this sense is emphasised by the confusion of tenses in this extract. Rachel described that:

...when I would talk [to my supervisor] about trauma cases, I would talk about all the gory detail, and I suddenly noticed how she would really wince in her chair – she'd go ‘ooooo’ – and she had these really strong reactions (...) So I think that [her] having that gesture response, that has helped me to have a gesture response with my patients. And I think it does make you more human...

In this account it appears that her supervisor's visible and bodily response to her descriptions allowed her to be “more human. That it took some years indicates that this

was not a straight-forward endeavour. Similarly, Serra particularly valued a supervisor who modelled qualities of emotional openness:

...when I was talking about my feelings and everything, his response to me was, 'I know that there is no way you're going to act out anything, so why are you trying to scare me? I am not scared. I know that nothing unsafe is going to happen. I know you, so why are you trying to scare me?' (...) So even in the presence of quite dangerous feelings, he was able to stay with me, and allow me to stay with it, and eventually it worked very safely and very well.

In this example, Serra describes her supervisor extending her ability to contain her own feelings. The words "I know you" are quite striking in terms of a communication of faith in Serra's capacity to work with strong feelings. Thus Serra's supervisor's belief in her played a vital role in her reaching a position where she has faith in her own emotional process.

4.4.3 'You have to find a way to resolve that in yourself': Reaching a place of acceptance and hope

Through the emotional difficulties of engaging with trauma, five participants described reaching a point of acceptance in themselves in relation to traumatic material.

No matter what people say to me now, the chances are I've heard something similar, so the impact's already been and it's settled somewhere, really. So my

own responses, I know them (...) because, I suppose you work it out – you have to find a way to resolve that in yourself. (Nadia)

Here, Nadia conveys her experience of personal development in spatial and physical rather than temporal terms; that with experience, the impact of hearing about traumatic experiences has “settled somewhere”, giving a sense of this as a bodily process. The notion of finding a way to “resolve that in yourself” indicates a sense of inner conflict that previously existed; perhaps what was unacceptable to the self needed to be internalised as part of the therapeutic work. Again, the tentative phrasing suggests that this process is difficult to put into words. Nadia went on to describe her shift in perspective:

But what I think the difference is, you’re sad with that person as an adult who’s survived that and this is what I’m working with them now (...) I think, because people are coming out the other end of it.

Here, Nadia conveys a change of focus in reflecting sadly with the adult about what happened to the child. In addition, there is an emphasis on hope and recovery – a sense of being on a journey together where “people are coming out the other end”. Beth also described a position of acceptance, and for her this is centred around her capacity to put trauma into context:

...it’s about (...) putting it into context. And how can I put it, and just really accepting that you just have to get on with it. (...) It’s either you allow it to keep contaminating you and affect your behaviour and your life, or you accept that

actually you need to kind of – it’s hard to explain really – it’s about seeing things for what they are, rather than reading into it too much.

In this extract, Beth conveys her sense that this position is reached through both necessity – “you have to get on with it” – and choice: that either one continues to allow oneself to be contaminated, or one chooses to accept “things for what they are”.

Lucy described reaching a position of “calm”:

I’ve managed to distance myself a bit more – be a bit more calm myself, not as anxious when trauma came up (...). But you definitely develop a sense of calm – being able to listen, to take a second to digest.

Here, Lucy conveys that the value of being calm is that it actually allows her to listen, take in and digest the traumatic material. Similarly, Rachel, through her training and experience, valued having reached an internal position of calmness and strength:

There was like a calmness and peacefulness, knowing that you're with the person, but by the end of the therapeutic process, they would have calmness and the strongness.

In this extract, it appears that Rachel’s sense of inner calm is brought about by her confidence in the therapeutic process and her belief that the client will develop these qualities themselves. Serra also described reaching a point of acceptance, though for her, this is through sharing the client’s pain, whereupon the client begins to be able to stay with their own feelings, which she describes leads to a “unity in feeling and acceptance and hope”. Thus for Serra, there is a sense of natural progression, that by staying with

her emotions as they arise, together with the client, they will reach a position of acceptance and hope.

4.5 VALUING THE THERAPEUTIC SELF IN WORK WITH TRAUMA

Therapists spoke about the importance of particular personal qualities in working with trauma and the value of offering an extremely high level of interpersonal responsiveness. Participants also recognised a vital role for ongoing self-awareness and being responsive to their own needs when working with trauma.

4.5.1 ‘I was just being with him, to be honest’: Valuing personal qualities in work with trauma

The therapeutic use of self was highly valued by all the participants. Many of the participants discussed the importance of being highly responsive to each client’s needs when working with trauma. This involved being collaborative in terms of pace and when / how to work on material related to trauma. Beth summarised: “it’s working from the client’s – where they’re at”. Similarly, Elisa emphasised the importance of her responsiveness to the client’s process:

She was mute for a long time, so I had to just wait, working with writing on paper and just sitting (...) I’m not going to be agitated about doing something to sort her out – that she will eventually tell me what she needs, and how she needs to work.

Elisa conveys the notion that the client will eventually communicate what she needs, and that there is more value in trying to be attentive to this, rather than trying to “sort her out”. At times, being responsive involved an emphasis on the importance of the therapist’s presence and ‘being’ qualities:

I was just being with him, to be honest. (...) I just stayed with him when he was letting go of it, and then tried to gradually – when he was – when the emotion had lessened a bit, to bring him back again. (Timothy)

Here, Timothy repeats the word “just”, conveying a sense of the simplicity and yet power of ‘being with’ in enabling the client to go on an internal journey to let go of his traumatic memory and then come back to ‘reality’. These accounts appear to be based on a sense of trust in the client’s own capacity for healing, and Nadia made this more explicit:

I truly believe that people are designed in a wonderful way – the brain wants to heal, and it will find a way of healing (...) you just have to set up the conditions, really, and just facilitate something.

On the other hand, Rachel valued offering a contrasting emotional stance to the client:

Rachel: It's a kind of the person's got a hopelessness and a complete hopelessness and helplessness and – I don't know, I think almost like an opposite response – feeling strong, resilient – is actually quite productive.

Olivia: Almost like a counterbalance.

Rachel: Yeah, not having a person-centred mirrored response where we're both going to sit here helpless. Yeah – I can go there if I want to, but I keep thinking, it's almost like – no – it's kind of, like, I'm here in a strong part, and you have to get up to the strong part.

In this extract, rather than following the client's lead, Rachel's use of self involves taking the lead in trying to bring the client "up" to her position of strength. Michail, rather than either following or leading the client, argues for being responsive to what he perceives as the client's needs at the time:

The question is, then, how do you moderate [your response] and give it to the client in a way that's useful? D'you intensify a bit, d'you use more dramatic language, do you – are you a bit more reserved? But that depends on the state the client is in and what I judge would be therapeutic at that moment.

Here, Michail presents his use of self as highly reflective in that his responses are continually mediated by his considerations on what would be therapeutic. Michail further argues for the value of the therapist's reflective qualities in work with trauma:

The other thing is I think it's also about keeping the stories in mind (...) so we can think about them and make links with them. Because (...) I think what tends to happen is either the trauma, the event is not thought about, or significant others become fixed in it, if you like.

Here, Michail emphasises the value of his capacity for being reflective, and making links with the client as a developmentally needed quality that wasn't available at the time of the trauma.

Participants also conveyed a sense of reciprocity, in that, as challenging as it was to be so responsive, this was also experienced as highly rewarding, affording the self opportunities for development, and sharing the client's joy in the therapeutic gains. Most of the participants commented on finding the dramatic changes that they encountered in working with trauma rewarding. For example, Lucy highlights the personal growth and development that can come from meeting the challenges of working with trauma:

[The negative energy] can almost overwhelm you in the room, and then if you can master it and become really bigger than it, you develop – there's some magic in that.

This rewarding aspect of the work is described by Elisa even when the work is more challenging "it's been a very challenging journey, but very fulfilling as well. I wouldn't not have had it". Nadia states that what is rewarding is sharing in the client's experience of growth:

...you get a little share of that each time – you get a little share of the difficult stuff to begin with [and then] you get a share of somebody saying, 'phew, it feels really OK now'.

Some participants found all their experiences to be positive, even when the outcome was not what was hoped for, or the client dropped out of therapy, because they felt the client had still had the opportunity and the experience of therapy.

4.5.2 ‘Making sure you know where you’re at’: Valuing self-awareness in work with trauma

Four participants discussed the importance of self-awareness and self-reflection in working with trauma. Michail described this as an ongoing process:

We are dealing with stuff that provokes intense feelings, so I think I’m continually asking myself whether my responses, my interpretations, my interventions, my questions – what is the nature of my response?

Here, Michail highlights that when working with intense feelings it is valuable to engage in a continuous process of self-reflection, and Michail later links this to his ability to manage his countertransference responses. This also suggests the effortful and demanding nature of working with trauma, in terms of the constant self-reflection involved.

Beth stated that it is always important to think about how a particular trauma may resonate with one’s own experiences:

...we’ve all had our past traumas and (...) there was something that [the client] said (...) and my stomach went – and I thought, OK, I need to work this out and do something with this. I didn’t know what it was about or whatever (...) but [I] took it to supervision, and explored what had happened to me in that process.

Here, Beth conveys the importance of being aware of traumatic experiences in her own past and using supervision to explore the nature of her response. That Beth is unclear why she experienced this physical response highlights the value of the supervisory

relationship to make sense of this experience and its implications for the therapy. Beth elaborated on the questions she considers in relation to working with someone with a similar traumatic experience:

Am I getting over emotional? Am I distancing myself? Am I numbing myself from it? Am I disassociating? What's going on with the relationship? Am I over-identifying with this client?

This gives a sense of the tightrope-like balance needed when working with trauma in terms of neither being over-emotional nor too distanced and so on. For Beth, a vital part of this ability to achieve this was “making sure you know where you're at in that process” and using supervision and personal therapy to develop this capability.

Similarly, Serra valued her supervision in terms of encouraging a helpful awareness of her own feelings:

[My supervisor] is the sort of person who is aware of his feelings and who believes as a therapist it's very important to be aware of your feelings and emotions, and work with them, rather than try to suppress them or censor them, and talk about it, and everything.

Serra described such a stance as contributing to her own ability to work safely with her emotional responses in therapy with trauma. Here it is not only the supervision space that is valued as a reflective space, but the ethos of working with one's feelings as a therapist in a self-reflective way that is experienced as important.

4.5.3 ‘Its about psychologically keeping yourself safe’: Valuing self-care in work with trauma

In response to the demands of working with trauma, six of the participants discussed the importance of attending to their own well-being and needs. Beth stated:

I think it’s about psychologically keeping yourself safe (...) I make sure there’s at least half an hour where I can reflect and write anything down, get myself relaxed – decontaminate, if you like (...) so I’m really nice and clear and in a positive frame of mind for the next client.

Here, Beth sets out some strategies she uses to look after her own emotional well-being. The sense here is of valuing practices that involve “decontamination” – and indeed, Beth also speaks of supervision allowing her to “put down” her client work. Reflective space is viewed as contributing to her ability to be prepared and in the right state of mind for her next client. Similarly, Lucy also discussed the importance of space between client sessions:

I lit a candle between each session to clear the air – not in any magical way – (...) just to give myself a breathing space. (...) and sometimes I’ll do yoga [*laughs*] just a few stretches between clients if I feel I need to rid myself of stuff I’ve heard, or stuff I experienced so there are sort of physical things I do.

For Lucy, this “breathing” space is embodied in that it involves physical and sensory practices, perhaps linking to the notable physical responses to traumatic material that she described. Again, the notion of “ridding” the self of what has been heard and experienced suggests the way in which, as an antidote to the process of sponge-like

absorption, active steps need to be taken to “put down”, “let go” and “rid” the self of aspects of the therapeutic process, to maintain well-being.

Elisa similarly highlighted the importance of using physical processes to maintain her well-being. When Elisa’s client sat on the floor nearer to her, Elisa found that she was becoming more distressed herself and she wondered:

... do I go and change my clothes after being with her? Or do I wear a piece of jewellery that’s absorbing this energy, that when I’ve finished seeing her I can take it off? And I don’t know how much I believe in that, even, but it was useful to know that someone was writing about it so I thought, well, I’m not on my own here – there are other people who clearly get this vicarious trauma or whatever, and this is what I must be getting.

There is a sense of the importance of Elisa being able to regulate the distance from her client’s ‘energy’, either through physical space in the sessions or through the use of physical objects. Elisa conveys a sense of uncertainty in understanding what is going on, but, it appears that what mattered most in discovering the theory on vicarious trauma was a recognition that “I’m not on my own here”. In addition to personal therapy and supervision, Serra valued both physical and spiritual practices in support of her personal growth and self care:

I think what helps is I do lots of stuff around Buddhist meditation (...) and body movement workshops and stuff, and Thai Chi – that sort of thing – I think they helped a lot.

All the participants discussed the importance of supervision in terms of their own psychological needs. For example, Elisa stated:

It felt hugely important just to be able to tell (...) Anything like whether or not I was going to go to the GP, I would talk to her at some length. Whenever she got abused I'd tell her (...) So sort of somebody there you get a bit more of a picture than I could possibly share with anyone else.

For Elisa, as for many of the participants, supervision was needed in terms of making decisions and managing risk, but as importantly there was a need to be witnessed. The image of sharing a picture together communicates the value of not being alone with this demanding work. A number of participants also discussed the value of having an awareness of one's own limitations, and as an aspect of this, being mindful about the balance of their caseload. For example, Lucy states:

I find as a psychologist it's easier not going through the mill and being traumatised all the time (...). It's much better when you only have one or two trauma clients at a time and you can take your time working through it yourself.

In the same vein, Beth discussed the importance of balancing the type of trauma one works with, to prevent it becoming "mundane" or the self from being "saturated" by it. The sense here is that with too much of the same work, one will no longer be emotionally alive to it.

In this results section I have described each of the four superordinate themes and the constituent subthemes, and illustrated them with close analysis and interpretation of

participants' experiences. These findings will now be developed in the discussion section that follows.

5.0 CHAPTER FOUR

5.1 DISCUSSION

5.1.1 Overview

In this section I briefly summarise the overall findings from the results section and then consider which theoretical frameworks might offer the most helpful approach to making sense of these findings. The findings are also discussed in relation to existing research in this area, as well as the theoretical literature.

In IPA there is a ‘double hermeneutic’ (Smith & Osborne, 2003) in that the researcher is attempting to make sense of the participant making sense of their experience. Further, in terms of the researcher’s interpretations, Smith et al. (2009) discuss the hermeneutics of empathy and questioning, based upon Ricoeur’s distinction between a hermeneutics of empathy and a hermeneutics of suspicion as described in the methodology chapter. In relation to the analysis in this thesis, my aim has been to balance the tension between, on the one hand, engaging with participants’ experience in their own terms, thus prioritising the participants’ own perspectives (a hermeneutics of empathy), and on the other, developing the analysis through what Smith terms a hermeneutics of questioning. When adopting a hermeneutics of questioning, the interpretation should arise from and be grounded in participants’ accounts, but needs to go beyond the way in which participants makes sense of their own experience. Thus, Smith and colleagues discuss the value of making links with wider theoretical literature as part of the interpretive enterprise, while ensuring that the analysis remains grounded in participants’ accounts. In the discussion to follow I develop my analysis through a hermeneutics of questioning

in that I consider the participants' experiences in relation to theoretical ideas that add another layer of meaning to the findings in relation to the research question.

The structure of the discussion parallels the structure of the results section, beginning by considering issues relating to the demands and challenges in the use of self in response to trauma, followed by dimensions of complexity in working with trauma, developing the therapeutic self and finally valuing the therapeutic self in work with trauma. Some suggestions for further research are mentioned in the main body of the discussion, and these are considered in greater detail, along with other research suggestions, in the subsequent section. Implications for practice are considered, and the study is critiqued in terms of methodological issues and researcher reflections, closing with a final conclusion.

5.1.2 Selecting a theoretical framework

The analysis presented in the previous chapter presents four main findings. Firstly, participants described a number of struggles in terms of their use of self in response to traumatic material, including struggles in bearing the feelings and bodily sensations aroused in them, difficulties in knowing what, if anything, to share of their responses with their clients, and grappling with complex and challenging dynamics within the therapeutic relationship. Secondly, participants discussed grappling with differing conceptualisations of trauma and the implications arising from these conceptualisations – namely, the challenge of engaging with the wider social context of trauma, and the moral and political implications of taking a stance in relation to trauma. Thirdly,

participants conveyed the way in which their therapeutic selves were developed over time, through formative training and therapeutic experiences. Fourthly, the therapeutic use of self was highly valued by all the participants: Participants spoke about the importance of particular personal qualities in working with trauma and the value of offering an extremely high level of interpersonal responsiveness.

A number of different theories could potentially offer a way of making sense of certain aspects of participants' experiences. For example, the psychodynamic theories of transference-countertransference processes, including the notion of projective identification, were considered as a way of making sense of the complex interpersonal dynamics experienced by participants. However, it was more challenging to identify a theoretical framework that might both link and deepen the understandings developed in the results section. Two possible theoretical frameworks were identified – Fonagy and Target's (1996) developmental theory of 'mentalization' and Jessica Benjamin's (1990, 1995, 2000) intersubjective concept of 'mutual recognition'.

Mentalisation has been described as "the mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs and reasons" (Holmes, 2010, pp. 9–10). This potentially highlights the challenge to the therapist's capacity to make sense of the unimaginable – to reflect with their clients' on their own mental states and those of others in relation to traumatic experiences. In addition, this theory could help make sense of the difficulties faced by participants in terms of interpreting their own states and that of their client's in moments of complex interpersonal dynamics in the therapy. However, the concept of mentalization does not

link to all areas of participants' experiences, such as the challenges faced by participants when engaging with the wider social context of trauma.

In terms of making links between the different aspects of participants' accounts, the researcher considered that Jessica Benjamin's (1990, 1995, 2000) work on the concept of 'mutual recognition' offers an illuminating framework in that it allows for meaningful links to be made between intrapsychic, intersubjective and social and contextual meanings in participants' accounts. Therefore Benjamin's concept of 'mutual recognition' is discussed as a thread throughout the discussion, with the aim of linking and also enriching our understanding of participants' accounts.

Jessica Benjamin's (1990, 2000) work on the intersubjective concept of recognition draws upon Hegel's (1979) 'Phenomenology of Spirit' and the work of Jürgen Habermas (1981) and Axel Honneth (1995). Benjamin argues that 'mutual recognition' is achievable, and that it is the basis for the development of our subjectivity, our self-understanding and our self-acceptance (Butler, 2000):

Intersubjective theory postulates that the other must be recognized as another subject in order for the self to fully experience his or her subjectivity in the other's presence. This means, first, that we have a need for recognition and second, that we have a capacity to recognize others in return – mutual recognition. But recognition is a capacity of individual development that is only unevenly realised.

Benjamin (1990, p. 35).

The capacity for mutual recognition is discussed by Benjamin in relation to infant development. The mother's recognition of the growing infant is held to be the basis for the infant's sense of agency (Benjamin, 1990), and central to this is the notion that the relationship between the two is mutually impacting. Recognition is focussed on the capacity to recognise the otherness of the other – not to 'know' the other, or reduce the other to the 'same' but to uphold and cherish the difference of the other. Recognition always involves negation because the other never provides a perfect reflection of our own self image, and so to see ourselves reflected in the other results in changes to the self (Benjamin, 2000). Thus, these two processes of recognition and negation are in constant tension.

On this view, relationship breakdown occurs when there is a collapse of the dialectical tension between negation and recognition. In breakdown, the difference of the other is experienced as "unassimilable"; one is unable to recognise the other because their existence "is too alien (too negating) to our own sense of self" (Benjamin, 2000, p. 44). Benjamin describes relationship breakdown as "the relation between 'doer' and 'done-to' – the relation in which only one person can be subject, can decide on meaning, can determine the course of action, can get his way" (ibid.). Indeed, in their discussion of mutual recognition, Pollock and Slavin (1998) argue, "[o]ne can readily see how the experience of agency may be damaged in situations of trauma and abuse ... as a child's body and mind are usurped by the will of another" (p. 858). In this account, therefore, trauma in relationship is characterised by a dynamic where "only one person can be subject", which in turn inhibits the development of agency. Throughout the discussion, I will develop these ideas on recognition to make sense of the current results – to think

about why the participants considered their use of self in work with trauma to be so vitally important and at the same time so highly challenging.

5.1.3 Challenges in the use of self: Trauma, meaning and recognition

All of the participants described negative emotional responses to traumatic stories, including feelings of horror, anger, sadness and fear, and feeling overwhelmed by these emotions. Participants also described experiencing more explicit changes in meaning in response to traumatic material. They described looking out for potential dangers and being mistrustful of other people, and experiencing greater distress themselves. This corresponds to McCann and Pearlman's (1990) concept of vicarious trauma whereby in therapeutic work with traumatic material, the therapist may become more aware of the experiences of powerlessness, lack of safety and betrayals of trust that people can go through, resulting in distress for the therapist. Participants also experienced working with traumatic material as having personal implications, particularly when they shared biographical similarities with their clients, such as having children. De Zulueta (2006) notes how emotionally difficult it can be to work with trauma, in that the therapist witnesses the pain of living without the illusion of invulnerability.

Feelings of horror were commonly described by the participants, and this was associated with internal experiences that were difficult for participants to put into words.

Participants described not wanting to get into their "own version" of what had happened, and at times, participants conveyed the sense of not wanting to believe what they heard. Staying in a state of horror conveys a paralysis that is perhaps a form of self-protection:

“how can someone do that to someone else?” (Beth). How can the intersubjective theory of recognition help to develop a meaningful reading of participants’ experiences as described in the interviews?

Participants conveyed that working with people whose traumatic experiences involved violence to others (e.g. combat veterans and people who, having been abused, and then go on to abuse others) was particularly difficult. This was also a feature of working with clients who had been profoundly abused by family members; the desire to negate the abuser was held in tension with the acknowledgement of an attachment relationship between the family members and the client, that needed to be respected. Indeed, Beth experienced the loss of the illusion of ‘Otherness’ of those who carry out acts of violence and abuse to be highly distressing. Thus, participants expressed that they could not psychically negate the abuser / the client who had carried out acts of violence, but rather they needed to be able to think about and recognise them as an agentic subject, and to view their acts as meaningful. To make it conceivable that another agentic subject ‘did this’ requires us to shift what we understand a human subject to be, and thus what *we* are. Some of these thoughts and feelings are captured by Danieli (1966), who describes the shame of witnessing “the potential boundlessness of human evil and ugliness” (p. 229). Thus there may be a tension between the therapist’s role of making sense of people’s actions, and their capacity to ‘assimilate’ difference – in other words, to *recognise* the otherness of the other as opposed to negating the other entirely.

5.1.4 Dilemmas in the use of self

There was considerable divergence in terms of the ways in which participants made sense of their responses to traumatic experiences and how they attempted to work with their responses in the therapy. For the majority of participants, strong responses were viewed as anti-therapeutic and prevented them from carrying out their technical interventions effectively. They prized their ability to ‘step out’ of the pain in service of the therapy and also in order to protect themselves. However, a small but vocal minority of participants valued the embodied and intentional act of ‘stepping in’ to the client’s pain. This was experienced as an important way to help the client communicate their feelings, as well as to help the client gain the capacity to survive their emotional pain. Thus, there is a dilemma or tension running across participants’ accounts in that strong emotions are viewed as somewhat unprofessional, impeding therapeutic techniques, and simultaneously that this responsiveness was potentially valuable to therapeutic work.

The current findings add to existing literature in highlighting the way in which therapists may make intentional use of the capacity to ‘step in’ and ‘step out’ from emotional intensity in accordance with what they considered to be therapeutic. This capacity, they felt, enabled them to work therapeutically and flexibly with their clients, in bringing about greater emotional attunement at times, and at others a greater distance from emotional intensity in order to be able to ‘digest’ and think. What this research indicates is that although there are no hard and fast rules for the therapist experiencing strong emotions as being either therapeutic or anti-therapeutic, the participants tended to take quite clear-cut positions in relation to their own emotions, with some participants expressing the view that if they do experience strong emotions, this would necessarily be uncontainable for the client.

Further, many of the participants tried to limit the extent to which the client was aware of the therapist's feelings and subjective responses in order to contain the client and allow them the space for their own feelings. What was significant was the way in which participants considered their responses to be 'unprofessional' or 'professional'; it appeared that participants felt there were accepted therapeutic rules that they were not 'supposed' to show their responses to their clients. Thus, the current findings indicate something of a taboo in relation to self-disclosure, and particularly the sharing of strong feelings. However, other participants took a different position, with a minority arguing for the value of disclosure in order to acknowledge the 'understandability' of clients' responses, and also in order not to take up the position of a 'neutral bystander', which might replay features of the original traumatic situation.

It appears that the position taken by therapists was partly a function of their chosen ways of personally managing their own strong feelings in the dyadic work, and partly a function of therapists' conceptualisations of trauma and recovery. For those who viewed recovery to primarily involve the experience of the client of sharing their emotions with an empathic other, experiencing and even sharing their own emotional responses was prized. On the other hand, for therapists who focused more on the value of technical interventions such as EMDR, experiencing and expressing strong emotions tended to be seen as unhelpful.

In relation to empirical research, whilst the researcher was unable to find studies on self-disclosure with trauma, Henretty and Levitt's (2010) review of published quantitative studies exploring verbal therapist self-disclosure in therapeutic work in general concluded that self-disclosure had a positive effect on clients (including seeing the

therapist as warmer), and that ‘self-involving’ disclosures (sharing thoughts and feelings about the client) had a more positive response than therapists disclosing about themselves. Notably, when Michail used self-involving disclosure in conveying his anger about the violence a client had experienced, the client specifically remembered this as having been helpful in her feedback about the therapy. Though this was only one example, it was a striking one, and Henretty and Levitt’s review notes that disclosures may be so powerful because they are generally used sparingly. At the same time, Henretty and Levitt’s review indicated that self-disclosure is not recommended for clients with poor boundaries or who are diagnosed with personality disorders, and these issues have been linked in the literature to experiences of trauma (Lewis & Grenyer, 2009).

The current study highlights the hesitation of therapists in using disclosure in therapy with trauma. Indeed, even participants who argued for the value of disclosure were highly cautious about how they used it, and were very wary of how it might impact on the therapy. They were particularly concerned about the client’s concerns and fears about how their traumatic material might contaminate and even overwhelm the therapist. Hegel’s theory of the struggle for recognition, taken up by Benjamin (1990), may shed some light on this. The literature on recognition indicates that it is precisely the experience of having an impact on the other that can contribute to a sense of agency for the client. However, paradoxically, whilst there is powerful therapeutic potential in the therapist sharing the impact the client has on them, this is also inevitably negating: to see ourselves reflected in the other involves losing aspects of the self, as the other is never a perfect mirror. For more fragile clients, this could be experienced as highly threatening,

particularly when they have experienced relationships characterised by breakdown – where “*only one person can be subject*” in the past. This theory may make some sense of the ambivalence with which participants approached this issue of sharing the mutually impacting process of therapy and disclosure. Previous research has not explored the issue of disclosure in relation to working with traumatic material specifically, and the current study provides some initial insights on the issue and also highlights the need for more research in this area.

5.1.5 Embodied intersubjectivity

Participants described how working with trauma affected them in a number of unexpected ways, including being uncertain whether their feelings were their own or the client’s, and experiencing intrusive images of abuse and strong physical responses, including physically synchronising with the client. A number of participants described feeling “contaminated” by their therapeutic work with trauma; that the details of particular stories could “leak through” to them in sensory ways. In the psychological literature, such experiences might be accounted for by the concepts of somatic countertransference and projective identification or by theories based on intersubjectivity theory; these ideas will be addressed in turn.

Stone (2006) argues that when the client is unable to verbalise traumatic experiences, they are more likely to project their embodied feelings into the therapist. Ross (2000) expands on this idea and states that an understanding of somatic countertransference relies on the Kleinian concept of projective identification, whereby experiences which

cannot be expressed in words, including “disturbed, deficient and distorted early infant/carer relationships” (p. 465), lead to split-off somatic sensations that are projected into the therapist. Ross posits that these somatic sensations may be disturbing, yet they communicate a hope in the client’s capacity to have an impact on and be impacted upon by another. However, Stolorow et al. (2001) convincingly argue that the Kleinian concept of projective identification obscure[es] “the contribution of the analyst's organizing activity to the course of the therapeutic interaction” (p. 478). Thus the theory on somatic countertransference which is underpinned by the notion of projective identification is not consistent with the intersubjective premise of the current research and so was rejected as an explanatory model.

Merleau-Ponty’s (1958) argument, that embodied experience and interaction with others initially occurs pre-reflectively, has received considerable empirical support (see Gillespie and Cornish, 2010). From developmental psychology research studying finely tuned face-to-face communications from birth, Lyons-Ruth (2006) draws the conclusion that “the basic intersubjective flow of reading others' states and sharing aspects of our mental lives through the exchange of affective and intentional cues is a condition of our existence and cannot be switched on and off” (p. 602). Indeed, a considerable body of research indicates that much of the non-verbal information we communicate is communicated automatically, pre-reflexively, non-intentionally and outside of our awareness (Gillespie and Cornish, 2009; Ginot, 2009). Research into the mirror neuronal system, which indicates that when we witness another expressing an emotion, or experiencing pain, our mirror neuron system is directly activated in response, has been used by some theorists to shed light on our capacity to automatically and non-

intentionally resonate with the emotional states of others (Ginot, 2009). This seems to make some sense of experiences that participants described as visceral, sensory and physical, and which they were not sure to whom they belonged.

Notably, the participants in the current study did not experience their physical sensations and resonances to add value to their therapeutic work; they feared instead that these sensations distracted them from the work. In addition, participants tended to feel at a loss when clients were not able to verbalise their experiences. Indeed, as a talking therapist, to have a client who is mute for a long time, as two participants experienced, took them into unknown territory. In the current study participants were troubled by their own somatic processes, as well as feeling de-skilled and lacking in ability to work with clients' embodied experiences.

Ogden et al. (2006) argue that by attending to the body directly as they advocate in their 'sensorimotor psychotherapy' for trauma, it is possible to work with habituated trauma responses that are primordial, pre-reflexive and non-voluntary. Further, the same authors state that whilst psychological therapists are trained to attend to the client's body, working *directly* with the somatic experience is not an aspect of traditional talking therapy. This, they convincingly argue, leads to serious therapeutic limitations, and this notion is supported by the current research.

These findings support the existing qualitative research investigating the physical impact of working with trauma on the therapist (such as Steed and Downing's 1998 study), and contribute to research in this area by highlighting the difficulty experienced by therapists in working with their somatic processes. The current study also indicates that

consideration of embodied intersubjectivity in therapeutic work is still in its infancy, and certainly participants described being unsure about what to make of their experiences. In terms of the theory on mutual recognition and intersubjectivity, the embodied nature of intersubjectivity is arguably not sufficiently accounted for. The implications of ‘embodied intersubjectivity’ and therapists’ physical responsiveness to traumatic material are further developed later in the discussion.

5.1.6 Relational dynamics

Participants described a number of difficult interpersonal dynamics with clients who had experienced traumatic events. At times, therapists in the current study described themselves getting pulled into a rescuing dynamic through their own narcissism, stating that they got caught up in their own wish to be special and make a difference. At other times, participants described feeling protective towards clients, because of clients’ psychological vulnerability stemming from abuse they had themselves experienced. Where the client’s ability to take care of themselves was compromised, this led to ethical responsibilities for the therapist such as contacting the client’s GP. Some participants described this as getting caught up in the victim–rescuer dynamic with problematic implications for the power dynamic within the therapy. This links to existing literature (e.g. Dahlenberg, 2000) highlighting the experiences of therapists finding themselves acting out particular roles, frequently the rescuer, and sometimes the perpetrator.

Participants also experienced the relationship as pulling them to relate in a particular way that they felt was non-therapeutic. In these relationships there was a sense of fear

about what might be unintentionally communicated at the non-verbal level in the therapeutic relationship. Participants conveyed that it was hard to know where the self ended and the other began. Rizq (2010) describes the notion of the “‘relational’ unconscious... that is made up of relational schemas that come to be enacted within affective-interpersonal cycles generated between therapist and client” (p. 95). Participants’ experiences appear to relate to the theory on ‘enactments’, where therapist and client experience themselves becoming stuck in emotional positions:

Feeling as though they are reacting to ‘something’ in the other, both patient and analyst are unable to view the interaction from different points of view, or reflect on what it may mean. Neither is fully aware of the complex dynamics that have propelled them into their fixed affective positions.

Ginot (2009, p. 291).

The intersubjective concept of recognition can extend these ideas, in that recognition involves two subjects relating in a way that cherishes the perceived otherness of the other, without collapsing the distinction between self and other. In this way, enactments can be seen to arise between two subjectivities when the capacity for mutual recognition is lost. How might this be understood developmentally? According to Benjamin (1990) the development of agency is dependent on the experience of recognition and mutual impact with care-givers in early life. As mentioned earlier, Pollock and Slavin (1998) argue that with experiences of trauma, the development of agency may be impaired. Further, where there is impairment in terms of being recognised as an agentic self, the capacity to recognise the other is also impaired (Benjamin, 2000).

In the current study, participants described their concerns that their communications would be viewed as seductive. Serra understood this to be because the client's early experiences of relationship intimacy had been sexualised, and she described her fear that the communication between them was "untherapeutic". What it appears that participants were struggling with was that they did not feel able to make themselves 'recognisable' to the client – that their actions were being misconstrued by the client, and the participants' sense of agency in the therapy compromised. Ginot (2009) argues that whilst enactments inevitably involve the blurring of self/other boundaries, they are a valuable opportunity to gain an 'unmediated' experience with what the client cannot yet verbalise. Indeed, the experiences of misrecognition and the lack of agency experienced by the participants appear to correlate with the early experiences of their clients. In this way the experience perhaps provides the participants with direct access to relational patterns experienced by the client in earlier life.

Ginot (2009) states that by becoming aware of and reflecting on this experience with the client, the therapist offers the client the opportunity to recognise and even integrate what the client could previously only enact. However, this is not an easy task. Certainly, in the current study, enactments were experienced as extremely difficult to make sense of and to work with, and therapists addressed them by becoming highly boundaried and avoiding discussions about some topics that were considered problematic. Indeed, to be able to reflect on the experience of an enactment with a client, the therapist must have some confidence in the capacity of the client to be able to 'recognise' the therapist's communication – for their words to bring about an end to the enactment rather than deepen it. The current study thus highlights the considerable demands posed by

enactments for the therapist, and the participants' lack of confidence in their capacity to work therapeutically with them. This area therefore warrants considerably more discussion and attention in therapeutic literature, and research to inform training and supervision practices that may help therapists in working in this complex area.

On the other hand, healing relationship dynamics were also viewed as a valuable part of the therapy. Examples of these included building up a sense of trust within the relationship where before, people were viewed as untrustworthy and, for female clients, the therapist providing an opportunity to view relationships with men in a different light through a new experience of a relationship with a male therapist. In these examples, the experiences were presented as implicit within the therapeutic relationship rather than being explicitly discussed in the therapy. It was striking that this wasn't an aspect of participants' experience that came up more explicitly. Perhaps this was because of the challenges that participants experienced in the therapy relationship – that discussing the relationship directly would have been too risky. Nevertheless, the findings here support existing studies such as that of Cloitre et al. (2004), which highlight the importance and value of the therapeutic relationship in working with trauma.

5.1.7 Trauma as social, moral and political

In this research participants questioned how to conceptualise trauma; although they found the simple / complex trauma model to be a useful heuristic to make sense of clients' experiences and to inform their work, they noted that their clients' experiences did not always fit into this model. Thus, therapists' experience was valued above all else,

including therapeutic models, to inform therapeutic work. In addition, although articulating their understandings of trauma was difficult within the interview, participants stated that they know trauma when it is ‘in the room’. This indicates the role of tacit knowledge (Polanyi, 1958) in working with trauma. It also highlights the limitations of what participants were able to articulate in the interviews about the ways in which they worked. Nevertheless, the concept of trauma was valued, and Michail in particular noted the importance of the concept of trauma in highlighting real experiences of suffering behind so-called psychological ‘illness’.

Participants attempted to be responsive to what the client experienced as traumatic (rather than imposing objective definitions), and participants described their clients’ experiences of trauma as highly idiosyncratic and linked to the meanings within the client’s social context. This relates to Buirski’s (2005) intersubjective conceptualisation of trauma that “the subjective experience formed within a specific relational context ... will determine the meanings that the event has” (p. 113). Indeed, for some participants, especially for those who had experiences of living and working in different cultures, trauma could only be understood in relation to the socio-cultural context, in that what was considered traumatic varied in different countries. This meant that the therapist needed to ‘acclimatise’ when working in a different culture in terms of their empathic responsiveness to different traumas. Some participants valued locating their clients’ traumatic experiences within the wider social context to help make sense of clients’ experiences. For example, in Beth’s account, when she acknowledged the implications of the client’s disability in her abuse, this was experienced by the client as a very powerful recognition of her experience that had never been seen before.

It was striking that such different positions were taken by participants in terms of how they described their moral stance. Some argued for taking a position of moral neutrality. They indicated that this allowed them to inhabit the role of ‘healer’ most fully, with the clear aim “to get the human being well again” (Rachel). Others argued for the importance, and value, of taking up a moral stance in relation to trauma. Lucy emphasised the role of language (e.g. ‘trauma survivors’) in order to offer clients a more empowered perspective on their situation. Michail took this further, stating that it is not possible to take a neutral position, and he described focusing on power relations as a therapeutic aspect of his work to offer clients the opportunity to think about the way that power operates in their social contexts. Michail argued that being a ‘passive bystander’ is collusive, and therefore replicates features of the abuse in and of itself, and he linked this with the notion of the importance of the social recognition of the client’s experience. When describing the passive bystander, Michail depicted this as being a ‘dead face’. Evoking the image of a dead face put me in mind of the philosopher Emmanuel Levinas’ (1989) ethics of looking on the face of another:

The approach to the face is the most basic mode of responsibility... the face is the other who asks me not to let him die alone, as if to do so were to become an accomplice in his death. Thus the face says to me: you shall not kill.... My ethical relation of love for the other stems from the fact that the self cannot survive by itself alone, cannot find meaning within its own being-in-the-world.

(p. 137)

This most powerfully highlights the inextricably ethical nature of the intersubjective face-to-face interaction in our inevitable need of the other. In relation to trauma, Herman

(2001) and De Zulueta (2006) strongly advocate for the therapist standing in moral solidarity with the client, and they link this with the importance of social recognition of the impact of trauma. However, as McNally (2010) observed, trauma does not always have clear victim and perpetrator distinctions, and participants in the current research indicated their difficulties in relation to taking a moral stance when this was the case. For example, Beth described a conflict at times between her healing role and her own moral compass in working with a client who had been abused and gone on to abuse others.

Cooper (2009) states that “for many counselling psychologists, the essence of our profession... is that it is embedded in a particular set of values and ethics... counselling psychology is ‘ethics-in-action’” (p.120). However, the tradition within psychology of moral neutrality on the part of the therapist has arguably undermined due consideration of the moral stance of the therapist. Reinkraut (2008) argues that the “silence on matters relating to moral responsibility, justice and injustice tacitly collude[s] with an ahistorical, acontextual framing of individual suffering” (p. 8), and this results in a lack of consideration of social factors in therapy. Thus, the same author proposes that the therapeutic use of self should explicitly include one’s moral sensibility. However, the current study highlights the considerable complexity raised by these issues and the struggles of the participants in working with them. The issue of one’s moral position as a therapist was clearly important to participants, and it is interesting that it is not given greater prominence in the training, supervision and personal development of counselling psychologists. It was striking that participants appeared to be grappling with these issues entirely in isolation – compared to other issues, none of the participants described

discussing ethics in supervision, training, personal therapy or with colleagues. Perhaps, if this is the case, it may make some sense of the vastly different positions taken by participants in terms of an absence of collaborative thinking upon which to draw.

Nevertheless, perhaps a commonality in the participants' approaches was the attempt to offer their clients an experience of recognition. Butler (2000) notes that one of the strengths of Benjamin's intersubjective discussion of recognition is that it links psychological thinking with social theory on recognition in a helpful way. In the participants' accounts, thinking with clients about their experiences in terms of the social context and meanings included how the wider social context may allow trauma to happen, *naming* acts of violence and destruction as such, delineating how power works within the client's social context, and considering the implications of disability for ongoing experiences of abuse. In this way, clients were not treated in an acontextual way, but rather in a way that *recognised* their experience in meaningful social terms.

5.1.8 Developing the therapeutic self

All participants experienced changes to the self through working with trauma, though for some these changes were more dramatic than for others. Participants emphasised the significance of training and work with trauma early in their careers in terms of transition moments. A number of participants described shifts in the self that were made to cope with trauma, particularly during training. It was also evident that the course of development was not simply in terms of the *use* of self, but also in the way participants experienced themselves – in other words, in their personal development. Changes in the

self included becoming hardier and better able to cope with the details of traumatic stories without becoming overwhelmed, as well as, conversely, becoming ‘softer’ and better able to be emotionally responsive to traumatic material. Participants also described becoming more curious and less shocked in their responses to trauma, and developing therapeutic skills so that they were able to maintain empathy with clients without becoming ‘contaminated’.

A significant contribution to the development of the self was experienced in supervision. The value of supervision, for most participants, was less for the technical input and more for an experience characterised by recognition. The participants described as the need to be witnessed, to share the experience, to be ‘held’, and for supervisors to communicate their belief in participants’ abilities. Here, participants communicated something of the vulnerability that working with trauma raised in them, and the vital role of the supervisor in both recognising their vulnerability and also their agency. Indeed, for one participant, the experience of her supervisor stating “I know you” during a challenging therapeutic process was profoundly important to her capacity to engage in the therapeutic work. This supports existing theoretical literature (e.g. Herman, 2001; Hawkins, 2005) that highlights the value and importance of supportive contexts when working with trauma. The existing empirical literature, however, does not indicate that supervision has a role to play in maintaining therapists’ well-being (Kassam-Adams, in Sabin-Farrell and Turpin, 2003). Thus, the findings of the current study which indicate that therapists found it highly valuable to use supervision for their well-being run contrary to existing findings, and therefore indicate the importance of further research in this area.

Further, participants conveyed that through their work with trauma, they had reached a

position of acceptance in relation to traumatic occurrences. Reaching acceptance was described as having a *place* within themselves where they could hold dreadful things. Thus, acceptance was presented as an embodied experience rather than an abstract idea. This position was associated with the ability to bring a sense of hopefulness into their work with clients. Participants indicated that not only was this of benefit to them, but that it also benefited their therapeutic work. Acceptance was also experienced as a necessity – that unless you accept what happens, then traumatic material will contaminate you. This relates in an interesting way to existing literature on vicarious post-traumatic growth in that participants in the current study experienced positive changes in their therapeutic practice over time, but did not describe any positive changes in their own lives. The issue of the lack of substantial consideration of positive experiences is taken up later in the discussion. Nevertheless, the participants in the current study viewed reaching a position of acceptance as a central aspect of their development.

In terms of participants' descriptions of their use of self, there is an overall sense of a developmental progression towards being able to 'take in' traumatic material and then be able to think about it with the client, without experiencing this as unduly 'contaminating', and hence needing to defend the self from this. This was not described as having reached an end-point, but there was a confidence in the ability of the self to 'manage' this through supervision / therapy and ongoing self-care practices. This is consistent with research into the professional development of therapists, indicating that psychological distress decreases as therapists become more experienced (Adams and Riggs, 2008; Hellman et al., 1987; Rodolfa et al., 1988). What the current study

suggests, in addition, is that rather than automatically happening through experience, this development is achieved through actively engaging in these self-care and self-development practices. Further, the participants in the present study highlight the value of intersubjectively oriented supervision and therapy – experiences characterised by recognition – to facilitate their therapeutic use of self.

5.1.9 Valuing the therapeutic use of self

Participants valued their use of self in therapeutic work with trauma very highly. Central to this was the capacity to be highly responsive to the client's needs and the client's 'pace'. In this way it appeared that participants were attempting to recognise the client's agency and subjectivity, which at times were extremely fragile. Other participants valued particular qualities that they could provide, such as their resilience and strength, and the capacity to be reflective and make links with the client to make sense of their experience. The notion of the value of making links with the client relates to the concept of the importance of reflective functioning in the attachment literature (e.g. Brownescombe-Heller, 2010). This also links to the notion of recognition in terms of the capacity of the therapist to recognise the client as an agentic subject whose experiences, however seemingly incoherent, can be meaningfully linked and made sense of.

Self-awareness and self-reflective practices were also highly valued in work with trauma. Self-reflection was described as an ongoing process of considering the nature of one's responses to trauma, and this was valued as a way of managing one's countertransference. Where traumatic experiences resonated with the therapist's own

traumatic experiences, then this self-reflection was viewed as particularly important, and supervision and personal therapy were valued as ways to explore and understand the therapist's response. Thus, participants conveyed that their capacity for self-awareness and self-reflection was dependent on relationships characterised by recognition, and that these relationships allowed them to work safely with their own emotional responses. This highlights the importance of the context where therapy takes place in supporting the therapeutic work, and Sabin-Farrell and Turpin's (2003) review on vicarious trauma highlights that this is an area that has not been given much attention thus far in the literature.

Participants also conveyed the importance of actively carrying out practices to maintain their psychological well-being, and highlighted that this was an important aspect of sustaining their ability to work positively with clients. Participants discussed the importance of limiting the amount of trauma in their caseload as well as the amount of work with any one type of trauma, in order to prevent 'saturation'. This has been discussed in the literature on vicarious trauma (e.g. Sabin-Farrell and Turpin, 2003), however there is inconclusive evidence for this. What the current study highlights is that participants valued the ability to use their own judgement about their capacities and limitations very highly, and also appreciated the support of their work-places in making such decisions (for example, not to work with a type of trauma that had a particular personal resonance).

A significant aspect of self-care involved actively doing things to be able to 'put down', 'get rid' and 'let go' of traumatic material, as an antidote to the process of sponge-like absorption described in 'embodied intersubjectivity'. This was achieved through

supervision, reflective writing and also physical strategies such as changing clothes, moving their positions in therapy sessions, washing hands, and so on. Interestingly, as they described this, participants laughed and were almost dismissive about what they did, and this is certainly not ‘mainstream’ practice. Yet the work of Babette Rothschild (2003) (which was specifically mentioned by one participant) discusses practical, physical strategies for therapists to ‘unhook’ from unconsciously mirroring their clients’ physical postures, a process termed ‘body empathy’, which Rothschild convincingly argues is not well understood. It is interesting that when describing the physical practices that they carried out, some participants gave caveats and questioned their belief in these self-care processes. It therefore appears that these actions are perhaps not considered to be bona-fide psychological practices, but that they are valuable nonetheless. This indicates once again that the role of the body, as a resource but also a source of potential distress in therapy, is perhaps not given the consideration or research interest that it might warrant.

Participants experienced working with their subjective responses to be highly rewarding, and they described opportunities to share in the client’s joy and relief at the healing process. Participants valued this sharing of joy with their clients, but the researcher wonders what the implications of this were for the therapy, as reflections on this were not discussed in the interviews. Indeed, participants mentioned these experiences in response to the researcher’s question about positive experiences and did not expand on them, but rather seemed to view them as almost incidental. However, Spiegel (2000) describes developmental studies where:

In mutual gaze transactions, the caregivers’ facial expressions stimulate and

amplify the positive affect, the joy, of the infant. The experience of interpersonal oneness in joy is a source of vitality, aliveness, and vigour for the infant, which the infant seeks to reactivate. (p. 25)

Similarly, in relation to the literature on recognition, Benjamin (1990) argues that a vital component in mutual recognition is *pleasure*: “the pleasure in mutuality between two subjects” is of recognising that the other is “animated by independent though similar feelings” (p. 37). Whilst the theoretical literature suggests that attuning to another’s joy may in fact amplify the experience of positive emotions, there has been no empirical research thus far on this issue. The apparent lack of interest in the area of attuning to and amplifying positive emotions in therapy is surprising. Indeed, the positive psychology movement highlights the value of attending to human strengths and resiliencies as well as distress (Linley & Joseph, 2004). Further reflections on the lack of focus on participants’ strong positive emotions in therapy are discussed later in the reflective section of the discussion.

5.2 CLINICAL IMPLICATIONS OF THE STUDY AND SUGGESTIONS FOR FURTHER RESEARCH

The study appears to be the first study to investigate how therapists view their responses to traumatic material to impact on the therapeutic process. It is important to be tentative in considering implications from qualitative studies, which involve small samples.

Indeed, had the current study been carried out with different participants, there may have been different findings. Further, it is acknowledged that another researcher may have

made different interpretations of the interview transcripts. Nevertheless, the reader may be able to draw on the current study in terms of theoretical generalisations and applicability to their own professional practice and understandings (Smith et al., 2009). Since a number of clinical implications from the study and suggestions for further research are linked, it made sense to include them in one section as follows.

5.2.1 Towards socially contextualised approaches to trauma

The findings of the current study support the development of contextual approaches to trauma, that is, approaches that recognise the wider meanings and implications of clients' traumatic experiences. Contextually sensitive approaches in therapy could involve reflecting with the client on the meanings of their experiences within their social context. The current study also indicates the potential value of therapists considering with their clients ways in which 'recovery' from trauma may lie within social processes, such as addressing implicit power structures. Related to this point, one might question how far a dyadic therapeutic relationship is able to address trauma experienced in a wider social context (and this is a point made by one of the participants). In recognition of the potential limitations of psychological therapy, therapists may want to think with clients about extra-therapeutic resources, be they legal, social or cultural, that may be beneficial. Further, participants described some interesting experiences related to working with trauma in their particular contexts, including prison settings, private practice and residential settings. This was not the focus of the present research and so was not an area dealt with in detail, but would be a rich area for future research.

The current study highlights the considerable complexity raised by moral and ethical issues and the struggles of the participants in working with them. The issue of grappling with one's moral position as a therapist was clearly important to participants, and this highlights the value of giving the development of one's 'ethical sensibility', if it may be described in this way, much greater prominence in the training, supervision and personal development of counselling psychologists. In training this could involve discussion, debate, role-play and so on, the aim of which would be to give trainees a space to think through and develop their positions in relation to complex moral issues, such as the participants in the current study have described, and how they might respond to such issues.

5.2.2 Supervision and self-care

The findings of the current study indicate that supervision is valued by therapists in maintaining their well-being as well as improving their clinical practice. Participants also highly valued their personal therapy, yet this is no longer a requirement after training. Some therapists may feel sufficiently supported within supervision, but the current study indicates the importance of therapists having access to additional support, such as peer supervision as one participant described, when working with high volumes of trauma. Further qualitative research specifically investigating the role of supervision in working with trauma would be useful to inform practice in this area.

Participants described that when working with high volumes of trauma, they can become desensitised and may use defensive practices such as 'switching off' in order to maintain

their well-being. To investigate this phenomenon and its implications for the therapeutic work and the therapeutic relationship in particular, quantitative research could look at the relationship between specific measures of the therapeutic relationship and volume of therapeutic work with trauma, as well as levels of therapists' secondary traumatic stress / vicarious trauma. The relationships between these factors might shed further light on this issue, and whether there might be a generalisable phenomenon here in relation to working with traumatic material. In addition, qualitative research with therapists working with high volumes of trauma, such as in specialist trauma services, could explore therapists' experiences in this area in more depth.

In addition, participants discussed the importance of limiting the amount of trauma in their caseload, as well as the amount of work with any one type of trauma, in order to prevent 'saturation'. The current study indicates that therapists vary in the type and amount of trauma they feel able to work with, and that participants valued very highly the ability to use their own judgement about their capacities and limitations. Therefore the present study highlights the importance of therapists being able to maintain some control over their caseload, rather than there being a particular 'optimal' number of clients presenting with trauma that a therapist should work with that could be generalised across the board.

5.2.3 Embodied processes

In the current research, in their therapy sessions therapists felt unsure how to make sense of, and work with, difficult embodied processes of their own and those of their clients. In addition, participants engaged in a variety of physical practices for their own self-

care, but felt there was an absence of theoretical ideas to ‘legitimise’ these practices. This indicates that there is a need for greater focus on and awareness of physical and sensory processes in therapy with trauma, and on how to work with these processes. Indeed, Ogden et al. (2006) argue that there is a need to directly incorporate the body in talking therapies when working with trauma. Additional support in this area based on the existing theoretical and empirical literature could be provided to counselling psychologists through training and supervision. In addition, further research into therapists’ experiences of physical processes in working with trauma, as well as working directly with the body in therapy with trauma, is warranted.

5.2.4 Relational enactments

The current study highlights the considerable demands posed by complex relational dynamics such as ‘enactments’ for the therapist, and the participants’ lack of confidence in their capacity to work therapeutically with them. It therefore appears that this is an area where further input and support through supervision and training would be valuable. In addition this area warrants considerably more discussion and attention in the therapeutic literature, and research, to inform training and supervision practices that may, in turn, help therapists in working in this complex area.

5.2.5 Additional suggestions for further research

The current research indicates that self-involving disclosure is potentially a very powerful intervention in working with trauma, but participants were very hesitant and at times fearful of using this intervention. Further research could investigate the therapeutic impact of disclosure specifically when working with trauma in order to inform clinical practice. Extensive data on *clients'* experiences of the usefulness or otherwise of such therapist self-disclosure in the context of trauma work would be especially useful.

5.3 METHODOLOGICAL CONSIDERATIONS AND RESEARCH REFLECTIONS

In this section I will critically review methodological issues in the current study, drawing on Yardley's (2000) guidelines as discussed in the methodology section as well as intersubjectivity theory. The use of a phenomenological research method (IPA) enabled an exploration of the research topic without the imposition of abstract theories and preconceived hypotheses. The rich and in-depth knowledge of the research topic that this study has produced through close analysis of nine semi-structured interviews has highlighted the value and cogency of qualitative research.

5.3.1 Intersubjectivity

There are a number of methodological considerations stemming from intersubjectivity theory. Since intersubjectivity holds that interrelations cannot be reduced to the individual consciousness that either participant has of it (Frie & Reis, 2001), this

problematizes the use of interviews with therapists only as being an adequate and comprehensive means of representing the therapeutic work. Indeed, some of the participants noted the limits of their ability to talk about the clinical implications of their responses to clients' trauma, and expressed an interest in the client also sharing their experiences. However, both logistically and for well-known ethical reasons, it was not possible to interview both clients and therapists. Thus it is important to recognise that the participants' accounts do not represent the whole picture in terms of the therapeutic interactions they describe. The emerging literature on listening to client and user perspectives in the psychological therapies (e.g. House, 2003; Bates, 2005) perhaps means that in future, new, ethically sensitive methodological developments will enable the client voice to be heard more strongly when considering the kinds of issues being researched in this study.

Limitations of the research are acknowledged in that intersubjectivity theory highlights that we impact each other in ways of which we are not consciously aware (Ginot, 2009). Whilst participants were able to share their reflections, there would be aspects of experience not available for reflection. Gillespie and Cornish (2009) discuss the merits of observational and ethnographic research methodologies in order to engage with intersubjective meanings in ways that include embodied interactions. However, in researching psychological therapy processes, such methodologies (such as observing therapy sessions) are not feasible. It is possible that by using video recordings of the interviews, the research could have considered participants embodied responses in more detail, as well as the intersubjective interaction. This idea did not occur to the researcher for the current research, but reflecting on it subsequently, whilst it would have added

another layer of richness to the material, this would have been potentially problematic in terms of being able to reflect on the amount of material generated in a project of this size. As it was, I found it challenging to do justice to the amount of material generated by nine audio-taped semi-structured interviews. Nevertheless, this idea of videotaping interviews could be considered in future research grounded in intersubjectivity theory.

5.3.2 Sensitivity to context

When designing the research, I considered specifying in the inclusion criteria that counselling psychologists needed to be working in an NHS trauma service in order to ensure the research remained sensitive to context (Yardley, 2000). Basing my study on one context may have allowed for closer consideration of the impact of the working context for therapists' experiences and for their responses. However there are a very limited number of such services, and comparatively few qualified counselling psychologists working in these services. Indeed, the majority of my participants worked in a combination of settings, such as private practice and primary care, and through previous work had additional experience of other settings. As qualified counselling psychologists will have necessarily worked in a variety of settings through training placements as well as post-qualification work, they will have drawn their understandings of working with trauma from the richness of these different settings, making it difficult to talk about just one setting. Arguably, being able to talk about the differing and contrasting experiences in the different contexts, and how they made sense of this, added a richness to the participants' accounts which would have been missed if I had limited

them to descriptions of their work in one setting only. Nevertheless, I endeavoured to remain sensitive to the contexts that participants described throughout my writing and this resulted in the understanding that what is traumatic actually *changed* for participants who drastically changed contexts by moving to a different country, thus supporting the intersubjective conceptualisation of trauma discussed earlier.

5.3.3 Commitment and rigour

Rigour and commitment were demonstrated through the researcher's sustained engagement with the participants' material in the process of analysis. This helped to ensure that sufficient "depth and breadth" (Smith et al., 2009, p. 219) were achieved in the analysis and discussion sections.

A critique of the current study from the perspective of the requirement for commitment and rigour relates to my sample. My inclusion criteria for the study were quite broad: participants were required to be qualified chartered counselling psychologists with experience of working with clients who have experienced trauma. The reason for this was partly because I was concerned about the challenging nature of recruitment and partly because I did not have a clear theoretical rationale to specify additional criteria. I did consider specifying length of time post-qualification as an inclusion criteria, and, on reflection, had I done this, the study would have been more in line with IPA's emphasis on homogeneity. This could be considered a weakness of the current study. Smith et al. (2009) note that homogeneity should be in accordance with the amount of "variation [that] can be contained within an analysis of the phenomenon" (p. 49). In relation to the

current study, the amount of commonality across participants' accounts indicates that the diversity between participants was not necessarily problematic. Whilst the diversity in the sample can be considered a potential weakness in terms of the capacity of the current study to examine psychological variability in detail, arguably the variation was adequately contained within the current study.

5.3.4 Transparency and coherence

I have endeavoured to achieve transparency in the research process through using a reflective journal to maintain a reflexive stance throughout this thesis. I consider it valuable to provide further reflections on the interview process in this section, as follows.

I felt my own training as a counselling psychologist gave me an ability to stay emotionally present in the interviews, and to use this presence to collaboratively reach a certain depth of understanding in relation to participants' experiences. For example, at times I shared my sense of the horror or shocking nature of the stories participants described, and I found this disclosure prompted greater openness with participants who were somewhat hesitant to explore their inner responses. This highlights the ethics of interviewing, in that as a counselling psychologist one could perhaps use counselling skills to encourage greater openness than a participant intended. Therefore I attempted to remain mindful of this and be responsive to what my participants conveyed, both verbally and non-verbally, about their boundaries around what they were comfortable talking about.

In addition, interviewing other counselling psychologists, I felt perhaps that there was a level of shared understanding from the outset. This sense of familiarity may have meant that I was not coming 'afresh' to the material and would therefore make assumptions, thinking I knew what they meant, rather than maintaining an open curiosity in my interviewing style. Further, I wonder about my capacity to 'recognise' my participants and the stories they told me. Through my experience of 'contamination' as described in the analysis (pp. 75–76), I was aware that I might give more weight to participants' experiences of this in the analysis and discussion, so I made efforts to address this through reflective practice (for example by writing in my reflective journal) to ensure I engaged with all the different experiences expressed in the interview. At the same time, I feel that reflecting on my own experience of embodied intersubjectivity added depth to the discussion in this area.

In this study there was much less emphasis on connecting, rewarding or joyful moments in therapy than on the challenging and difficult aspects of therapy. It appeared more difficult for participants to think about ways in which their responses might be helpful to clients than it was to think about how they were problematic. Interestingly I repeated a number of times in some interviews that I was also interested in hearing about participants' positive responses, which participants found surprising. Nevertheless, perhaps I lost sight of this and got wrapped up in the compelling issues around the difficulties of participants' responses. On reflection, had I made it very clear to participants that I was interested in both positive and negative responses to traumatic material and their clinical implications at the beginning of the research, I might have facilitated greater focus on both aspects of experience.

Finally, through engaging with further reading and in-depth reflection I hope that I have sufficiently developed the coherence and persuasiveness of the argument advanced in the discussion. However, the degree to which I have met this criterion might be best assessed by the reader.

5.3.5 Impact and importance

In terms of the relevance and usefulness of the current study, given that counselling psychologists could routinely expect to work with trauma in their practice, I believe that the current study can be considered highly relevant to inform both theory and practice. In addition, the findings of the current study indicate areas for valuable development in relation to both training and practice, and this highlights the clear utility of the research.

5.4 CONCLUSIONS

The current study has provided rich, in-depth knowledge about the experiences of counselling psychologists working with trauma and how they experience their responses to trauma to impact on the therapeutic process. The literature on recognition has helped to make connections between, and add greater depth to, the results. Recognition presupposes that attaining subjectivity is a developmental achievement: “A theory in which the individual subject no longer reigns absolute must confront the difficulty that each subject has in recognising the other as an equivalent centre of experience” (Benjamin, 1990, p. 34). The current research has shown how challenging it may be to

achieve mutual recognition. Where a person's developmental experiences have not been characterised by mutual recognition but rather experiences where "only one person can be subject", the development of the capacity for agency may well be inhibited. Therapy potentially offers an experience characterised by recognition but the current study indicates that this involves many challenges.

Challenges participants described included the difficulty in bearing the feelings and sensations aroused in them when witnessing the client's experiences, and developing the capacity to think about the potential meanings of horrific acts in a way that recognises them as a product of human subjectivity. The current study also highlights the considerable demands posed by enactments – indeed, the experiences of misrecognition and the lack of agency experienced by the participants appeared to correlate with the early experiences of their clients. The current study indicates the central importance of embodied intersubjectivity in the clinical situation, and indicates that participants were troubled by their own somatic processes as well as feeling de-skilled and lacking in ability to work with clients' embodied experiences. Further, participants communicated something of the vulnerability that working with trauma raised in them, and the vital role of the supervisor in both recognising their vulnerability and also their agency. In addition, participants conveyed that their capacity for self-awareness and self-reflection was dependent on relationships characterised by recognition, and that these relationships allowed them to work safely with their own emotional responses.

Therapists responses were viewed as the cornerstone of therapy – vital and yet also problematic to clinical work. The current research discusses the participants' experiences using the term 'use of self'. This suggests the self being used as a tool, or an

instrument, in the service of the therapeutic work, almost as though the therapist makes use of the self in a controlled, masterful way. However, what the current research indicates is the extent to which the self was unknown, highly contingent and vulnerable. Participants expressed their need of supportive contexts that could offer them ongoing recognition to sustain them in this work. They found that there were experiences they could not make sense of, and that their bodies responded in unexpected ways that were difficult to understand in the therapy. In her work on recognition, Benjamin uses the concept of ‘surrender’ to refer to the beneficial use of the therapist’s uncertainty and humility in therapeutic work, particularly when working with challenging enactments. This is not submission but “letting go of our determination to make our reality operative” (Benjamin, 2004, p. 32). This perhaps links with what the participants described in their process of gaining a greater sense of acceptance in the self, and that this was an embodied process in terms of creating a place in the self where painful experiences could be accepted.

The current study also highlights the shortcomings of the theory on recognition, in that it does not give sufficient attention to the embodied nature of intersubjective interactions. Indeed, despite the cogency of theory on mutual recognition in making sense of and adding depth to the current findings, the theory is limited, in terms of its marginalising of the status of the body. Whilst, the rhythmicity of face-to-face, child–care-giver interactions as an embodied, intersubjective dance features in Benjamin’s (1990) developmental theory of recognition, this physicality is lost sight of in Benjamin’s theory once verbal communication begins. Notably, participants entered a theoretical vacuum when trying to account for some embodied processes, such as when clients were

mute, or when they felt the need to carry out physical practices to maintain their well-being in response to working with trauma. Thus, to illuminate the experiences of therapists working with trauma, the role of the body needs a much more prominent role. Perhaps we could turn to Merleau-Ponty's (1958) work on embodied intersubjectivity here. On Merleau-Ponty's view since we experience the world around us through perceptual faculties that are based in the body, our interactions occur initially pre-reflexively; thus, to exist as a body-subject means being innately interactional. For Merleau-Ponty, like Benjamin, ethical treatment of the other involves recognition of the interdependence of self and other, whereby self and other overlap and intertwine but are never reduced to the same (Crossley, 1996). Whilst there is potential value in supplementing the theory on recognition with a Merleau-Pontian account of embodied intersubjectivity, this would necessarily have significant implications for the theory on recognition. Further discussion of this is beyond the reach of this thesis, but the current study certainly highlights the value of such theoretical developments.

The research also highlights the considerable importance of developing socially contextualised approaches to working with trauma and the value of a supportive context for the therapist, involving responsiveness to the needs and limitations of the therapist. In addition, the current study indicates the need for further training and support to assist counselling psychologists working with trauma in three principal areas: in working with embodied processes, with enactments in the therapeutic relationship and with challenging ethical dilemmas. Limitations of the research and areas of future research have also been discussed.

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7.0 APPENDICES

APPENDIX 1: ETHICAL APPROVAL DOCUMENTATION

Thu, 13 May, 2010 16:43:09

Ethics Applications - Merriman, Olivia

From: "L.Rochard@roehampton.ac.uk" <L.Rochard@roehampton.ac.uk>
Add to Contacts
To: merrimao@roehampton.ac.uk; oliviamerriman@yahoo.com
Cc: L.Slade@roehampton.ac.uk; Jan.Harrison@roehampton.ac.uk;
A.Salm@roehampton.ac.uk

Dear Olivia,

Ethics Application (research student)

Applicant: Olivia Merriman
Title: The therapeutic impact of counselling psychologists' responses to clients' traumatic experiences: an interpretive phenomenological analysis.
School: Human and Life Sciences
Ref: PT10/042

I am pleased to confirm that the above application has been approved by Chairs action on behalf of the Ethics Board. We do not require anything further in relation to this application.

Many thanks,

Lemady

Lemady Rochard
Research Policy Officer
Research and Business Development Office
208 Grove House, Froebel College
Roehampton University
Roehampton Lane
London
SW15 5PJ

T: +44 (0)20 8392 3256
E: L.Rochard@roehampton.ac.uk

APPENDIX 2: PARTICIPANT RECRUITMENT ADVERTISEMENT



New Research On Trauma: Participants Required!

I am a third year trainee on the Doctorate in Counselling Psychology at Roehampton University. I am researching the experiences of therapists working with clients who describe traumatic experiences, and how therapists consider their responses to the disclosure of traumatic material to have impacted, if at all, upon the therapeutic process. The project is supervised by Dr Richard House at Roehampton University.

Participants are required to be qualified chartered counselling psychologists with some experience of working with trauma. The research involves taking part in an audio-recorded, semi-structured interview of approximately one hour. This will be arranged at a time and place of your convenience.

It is very much hoped that taking part in this research would be an enriching experience in terms of providing an opportunity to reflect on, and discuss, your therapeutic work as well as making a valuable contribution to knowledge in the field of counselling psychology.

If you are interested in taking part in this research project, or would like further information, please contact the researcher, Olivia Merriman:

oliviamerriman@yahoo.com or 07980 310 906.

APPENDIX 3: PARTICIPANT INFORMATION SHEET



PARTICIPANT INFORMATION SHEET

Title of Research Project:

The therapeutic impact of counselling psychologists' responses to clients' traumatic experiences: an interpretive phenomenological analysis

Brief Description of Research Project:

The proposed research will investigate the experiences of therapists working with clients who describe traumatic experiences, and how therapists consider their responses to the disclosure of traumatic material to have impacted, if at all, upon the therapeutic process.

Investigator Contact Details:

Olivia Merriman
School of Human and Life Sciences
Roehampton University
Whitelands College,
Holybourne Avenue,
London, SW15 4JD
Email: merrimao@roehampton.ac.uk
Telephone: 07980 310 906

Purpose of research:

You are invited to take part in a research project carried out by a trainee counselling psychologist as part of a Doctorate in Counselling Psychology.

Given the importance of the therapists' subjectivity in the therapeutic process and the prevalence of trauma experienced by mental health service users, an exploration of the way in which therapists' responses to traumatic material may impact on therapy would be valuable to the field of counselling psychology.

Who can participate?

Participants are required to be qualified chartered counselling psychologists. In addition, participants should have experience of working with clients who have experienced trauma usually involving one or more of the following: sexual or physical abuse, experiences of military combat, terrorism, mass violence and natural disasters and accidents.

What will be involved in taking part?

The research involves taking part in a semi-structured interview of approximately one hour. This will be arranged at a time and place of your convenience. The interview schedule will consist of questions that will explore your experience of working with clients who have disclosed traumatic experiences, and how you understand your subjective responses to the descriptions of traumatic material to have impacted, if at all, on the therapeutic process. Interviews will be audio-recorded and will be followed by a debriefing process.

Confidentiality and Anonymity

All names and identifying details from the interviews will be changed for transcription. You will be offered access to completed transcripts to ensure exclusion of identifying details and accuracy. The debriefing form will include an ID number that you may use in the event that you wish to withdraw. The interview transcripts and any forms you sign will be stored in separate secure locations. Both the interview recordings and transcripts will be destroyed once the university's mandatory ten-year retention period has elapsed.

In terms of limits to confidentiality, if any information is disclosed in the interview process that indicates a danger of harm to yourself or others, or is unethical according to the BPS Code of Conduct & Ethics (2006), confidentiality may need to be broken.

Information to consider before participating

Participation in the research is entirely voluntary and you have the right to withdraw from the interview process at any time, although if you decide to withdraw once the project has already been written up, the researcher retains the right to use aggregate data from the study.

It is important to note that talking about your work with clients who describe traumatic experiences could lead you to reflect on distressing or difficult experiences. It could also lead you to re-evaluate your present practice in terms of how your subjective responses influence your therapeutic work. If this possibility is of substantial concern to you, then it is advisable that you think seriously before participating in this research project.

How will you be debriefed?

After the interview there will be an opportunity to talk about any issues that arose for you in the interview process and for you to ask any questions you may have. You will

also be provided with a list of sources of support, which you can draw upon if you experience any difficulty or distress as a result of taking part in this research project.

What are the potential benefits of participation?

It is very much hoped that taking part in this research would be an enriching experience in terms of providing an opportunity to reflect on, and discuss, your therapeutic work.

If you are interested in taking part in this research project, please contact the researcher, Olivia Merriman, using the details on this form.

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party, please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

Dr Anne-Marie Salm
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue,
London, SW15 4JD
Email: A.Salm@roehampton.ac.uk
Telephone: 0)20 8392 3618

Dean of School Contact

Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College,
Holybourne Avenue,
London, SW15 4JD
Email: M.Barham@roehampton.ac.uk
Telephone: (0)20 8392 3617

APPENDIX 4: PARTICIPANT CONSENT FORM



PARTICIPANT CONSENT FORM

Title of Research Project:

The therapeutic impact of counselling psychologists' responses to clients' traumatic experiences: an interpretive phenomenological analysis

Brief Description of Research Project:

The proposed research will investigate the experiences of therapists working with clients who describe traumatic experiences, and how therapists consider their responses to the disclosure of traumatic material to have impacted, if at all, upon the therapeutic process.

The research involves six to eight participants taking part in a semi-structured interview of approximately one hour. This will be arranged at a time and place of your convenience. The interview schedule will consist of questions that will explore your experience of working with clients who have disclosed traumatic experiences, and how you understand your subjective responses to the descriptions of traumatic material to have impacted, if at all, on the therapeutic process. Interviews will be audio-recorded and will be followed by a debriefing process.

Participation in the research is entirely voluntary and you have the right to withdraw from the interview process at any time, although if you decide to withdraw once the project has already been written up, the researcher retains the right to use aggregate data from the study. The debriefing form will include an ID number that you may use in the event that you wish to withdraw.

Investigator Contact Details:

Olivia Merriman
School of Human and Life Sciences
Roehampton University

Whitelands College,
Holybourne Avenue,
London, SW15 4JD
Email: merrimao@roehampton.ac.uk
Telephone: 07980 310 906

Consent Statement:

I have read the information sheet and I agree to take part in this research project, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party, please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

Dr Anne-Marie Salm
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue,
London, SW15 4JD
Email: A.Salm@roehampton.ac.uk
Telephone: 020 8392 3618

Dean of School Contact

Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College,
Holybourne Avenue,
London, SW15 4JD
Email: M.Barham@roehampton.ac.uk
Telephone: 020 8392 3617

APPENDIX 5: PARTICIPANT DEBRIEF FORM



PARTICIPANT DEBRIEF FORM

Title of Research Project:

The therapeutic impact of counselling psychologists' responses to clients' traumatic experiences: an interpretive phenomenological analysis.

Brief Description of Research Project:

The research will investigate the experiences of therapists working with clients who describe traumatic experiences and how therapists consider their responses to the disclosure of traumatic material to have impacted, if at all, upon the therapeutic process.

Investigator Contact Details:

Olivia Merriman
School of Human and Life Sciences
Roehampton University
Whitelands College,
Holybourne Avenue,
London, SW15 4JD
Email: merrimao@roehampton.ac.uk
Telephone: 07980 310 906

ID Number:

Debriefing:

After the interview opportunity there will be an opportunity to talk about any issues that arose.

Support Resources:

If the interview has raised personal concerns, it is recommended that you discuss these with your supervisor or therapist in the first instance. Further sources of support are detailed below:

British Psychological Society (BPS)

Website: <http://www.bps.org.uk/>

Tel: 0116 254 9568

British Association for Counselling and Psychotherapy (BACP)

Website: <http://www.bacp.co.uk/>

Tel: 01455 883300

United Kingdom Council for Psychotherapy (UKCP)

Website: <http://www.psychotherapy.org.uk/>

Tel: 020 7014 9955

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party, please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

Dr Anne-Marie Salm
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue,
London, SW15 4JD
Email: A.Salm@roehampton.ac.uk
Telephone: (0)20 8392 3618

Dean of School Contact

Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College,
Holybourne Avenue,
London, SW15 4JD
Email: M.Barham@roehampton.ac.uk
Telephone: (0)20 8392 3617

APPENDIX 6: INTERVIEW SCHEDULE

Interview Schedule

1. Can you tell me about your experience of working with clients who have disclosed traumatic experiences.
Prompts: What is the setting? What main therapeutic orientation do you work with?
2. Could you describe any memorable internal responses you had to clients who talked about traumatic experiences and what you made of them?
3. In what ways, if any, do you think your response, overt or 'internal', to a specific client's description of traumatic experiences might have had an impact on the therapy?
Prompt: Your answer can encompass both conscious and unconscious levels of experience, if relevant/appropriate.
4. How would you describe the therapeutic relationship with this client / these clients changing over time?
5. What do you think was your most positive experience in working with clients who disclosed trauma and how do you make sense of this?
6. What do you think was your most negative experience in working with clients who disclosed trauma and how do you account for this?
7. Is there anything that has helped or hindered how you work with your subjective responses in therapy with trauma?
Prompts: Training? Supervision?
8. In what ways, if any, do you consider the way you work with your subjective responses in therapy with trauma to have changed over time?
Prompt: What if anything, has contributed to this?
9. Are there any other comments you'd like to make in relation to the research theme?

APPENDIX 7: AUDIT TRAIL - TRANSCRIPT

Interview 4 with initial notes and emergent themes

Initial Notes	Transcript:	Emergent Themes
	<p>Could you start by telling me a bit about your experience of working with clients who have experienced trauma?</p> <p>Well, I originally trained in [country of origin]. So there's a huge part of our training - we actually do it in undergraduate and postgraduate where we do trauma training specifically in trauma – debriefing, and trauma defusing which is on-site trauma work – if you go on-site going with paramedics to crime scenes or accident scenes – which I did – the training was quite enough for me to do that. And the debriefing model that we used was Mitchel's model – it was a model they developed in the United States army. It was very military like – they wanted you to do the first de-briefing within 48 hours, which is quite different from the UK models where they actually leave people for about 2 weeks before they start working. So, my initial exposure to trauma was quite dramatic in that sense where you really had to stand your ground and be steeled and be grounded in working with trauma. But also, it suited the environment – [country of origin] is a very violent, traumatic country, so you had to be prepared to work with</p>	
Trauma-oriented training involved specific techniques		Training oriented towards trauma
Trained in specific trauma techniques – seen in military context		
Military model of working with trauma is very time bound		Trauma models linked to the military
Hardiness needed in trauma work		Hardiness needed when working with trauma
Tough imagery to convey qualities needed to work with trauma in that context		
Context of		Traumas different in

violence – daily rapes and murders	murders and rapes sort of, on a daily basis and so those were the initial things working with trauma, and when I came to the	different contexts
Contrast with UK – low key and less exciting	UK (laughs) I almost lacked the adrenalin rush that you get from a daily dose of good old-fashioned trauma. But now I find working with trauma much more rewarding and also cos I	
More rewarding to work with trauma when less common	can take a bit more time, it's not so rushed, it's not so part of every-day culture – it's quite special when it happens – when it comes your way. And you can explore with different ways	Preference for working with fewer trauma cases
Being able to explore – not restricted by approach	of working with it. So I find as a psychologist it's easier not going through the mill and being traumatized all the time and	
Also better personally – less secondary trauma	having sort of secondary trauma, it's much better when you only have one or two trauma clients at a time and you can take your time working through it yourself.	
Better to have a lower number of trauma cases on case-load	So there's something about how much you're working with trauma, that you can work in a different way?	
	Yes.	
	If you're working entirely with trauma clients it sounds like it's actually quite a difficult experience?	
	Yes – you get a bit like a paramedic or a fireman who sees so much of it that the only way to cope with it is to become	
With high quantities of trauma become more like a technician – have to adapt self to cope – 'black humour' -identity /	humorous about it in a very black-humour sort of way, and you start to only associate with people who share that viewpoint. We had that experience in our training group,	Changes in identity through working with trauma

identification shift	where one part of group began working with the fire-brigade and they became a very close clique because nobody could share the level that they experience of trauma where we would deal with soft emotions and grief and little things in their eyes – they were dealing with the hard-core suicides, all sorts of gruesome stuff.	Hierarchy of traumas
Exclusive clique – others can't share the experience. 'Soft' emotions minimised.	So something about the different ways it shapes your identity and then afterwards who you can identify with? When it's so raw, yes. And it sounds like the training experience in general was something quite shocking? Quite difficult?	Harsh training necessary for extreme trauma
Difficulty of training but necessary to be able to deal with the work	Yes it was. It was. I think it was quite necessary – we needed to be able to work with all sorts – with everything because there's such a shortage of skills, you really had to be hands on and be able to deal with everything. At the same time, it did do secondary trauma, no doubt.	
Training inflicted secondary trauma	And were particular parts of the training the ones that created that secondary trauma? Erm, I think the training, the initial training we received were [sic] from experienced traumatologists, as they're called, so they had no qualms in almost trying to shock us into what could happen, and hearing their experiences of people and members of the group who went on these things and what they	
Shocking strategies used in training		Extreme challenges of training
Shocking		

stories – off putting to working with trauma

Trauma unavoidable in therapeutic work

Damaging to be exposed to such gruesome stories while training

Trauma exposure should be gradually increased

Not a choice to work with trauma

Shocking shift in perspective about what can be traumatic to people

Subjectivity of what is traumatic for people in different contexts

Empathy needs

saw – it was absolutely shocking, and it almost really put me off working in that field. But then trauma would come across your path just in a normal practice, so dealing with one thing at a time was much easier than having a practice full of trauma.

What did they describe?

Yes – the first case that came to mind – there was some Satanistic rituals being performed on children and they had to go with the families to the scenes and saw the bodies, and it was very gruesome and traumatic and, I think, damaging to both the students who saw it who were 19, 20 years old and to us who had to hear what they saw. So there's some things I think as a student you probably don't need to be exposed to yet – you probably can hear it in theory until you're at least graduate based.

And yet you decided to carry on with that route...

Not really by choice – it's just if you practise in [country of origin] there's not really a choice – that's what you feed on – your main life fee [inaudible] goes through that. So when I came to the UK, I'll be honest I was a bit shocked about the things people go to a psychologist for – I'm being bullied at work – really? (Laughs). But you quickly learn that that is just as traumatic for that person as the daily trauma in [country of

Training damaging the students

Questioning the ethics of training methods

Context defining way in which work with trauma

Subjectivity of what is traumatic for people in different contexts

to be
redeveloped
according to
this
perspective

Enjoying
structure of
therapy with
trauma

Trauma now
unexpected

When trauma
is unexpected it
is more
touching

Urgency in
dealing with

origin] is to those people, so it's just a perception idea. And then developing the empathy for that so now I'm almost, I'm almost a bit soft in working with trauma – but I do like it and I do like the structure there is around working with trauma.

Can you say a bit more about being soft?

It's not something that I really expect any more. When I have a client walk through the door and we'll work for months, I don't really expect to hear trauma as much – unless it's in the referral but it's not something that comes to mind immediately when someone phones up to say 'I need to see you urgently'. Because it could be an emotional crisis and that's fine – it's not necessarily a physical danger or I've been through a trauma...

There's something you enjoy about being soft with trauma now.

Yes I do, because while on the one hand it comes a bit unexpected so I think it does touch me on a different level, but it also allows me to take more time with it. There was a sense of urgency and of having to resolve this trauma we had as traumatologists in [country of origin]. But there's much more 'take your time' – almost a peaceful way of dealing with trauma from living in a first-world country.

And you said it touched you on a different level?

Recalibrating
empathy in
different
contexts of
trauma

Changes in
expectations
about trauma

Contextual
differences in
pressures for
resolving
trauma

trauma in
[country of
origin] –
contrast of
being able to
deal with
trauma
peacefully in
the first world

Urgency in
dealing with
trauma in
[country of
origin]
Less urgency
allows more
healing time
and can be
more reflective
as a
practitioner

Working with a

Yes – yes, so for instance I worked for a company in [country of origin] that was dealing with corporate issues – as a psychologist – and when they had traumas within the company I would be phoned up and I would have to race there in my car. and I had to de-brief teams of people, or teams of board members, or whoever was affected, if there was a suicide in the company, or if there was a car accident and somebody they knew died so there was a big urgency out there – a big huff around it. When I recently worked with two types of traumas with train drivers, and these were referrals that was made 9 months on and 6 months on, and that sense of urgency – of having to sort it now – isn't there? Which also allows patients a lot of healing, but it also allows you as a psychologist to take a step back and see the wood from the trees.

Can you think of any memorable internal responses you've had when working with trauma?

Er, let's think. [Pause] I guess the two that come to mind – the one perhaps because it's public knowledge and everyone's been affected by it – I worked with someone who witnessed 9/11... actually worked in New York and worked for [company]. We worked for many years, and I don't think resolved anything too much for her, but that ... the public

Value of
having more
time to work
with trauma

trauma that's in public knowledge feels more personal and shared

Working through specific incidents as rewarding

Initial anxiety, discomfort and feeling the client's fear when working with trauma, and then later excitement

Using energy buzz creatively

Transforming the negative energy of trauma internally and sharing that

Mastering and becoming

knowledge of the shared trauma in it – everybody – when you say 9/11 you know where you were when you heard about it.

So there is something about it that feels a bit personal. I guess that was one, and the other was a child abuse case I worked on with a long term patient – she was – well, she was abused as a child but then also later on by her husband, and she allowed me to work very specifically on the incidences as individual experiences of trauma, and that was a unique piece of work – it was like little pieces of trauma work over a stretch of time which I found quite interesting and rewarding because we managed to really resolve things.

And can you describe your internal feelings?

I think with her there was a sort of an excitement which initially when I worked with trauma there was a lot of anxiety and a lot of discomfort and a lot of transference, if you want, where I would really feel their fear, but this was more recently

– I'm a bit more mature now. So I managed to almost use that – that buzz, that energy in a creative way and produced the most amazing creative experiments with her, and she bought into it so it was a really great energy about using this very negative energy and having to master it to make her buy into my rephrasing of it, really. And reframing it - that sort of gives trauma a really nice sense to work with. That you can

Different traumas resonate differently

Changes over time in internal responses to trauma

Working with negative energy and mastering it

bigger than the negative energy allows personal development

use this really awful [inaudible], that you hear about, and it can almost overwhelm you in the room, and then if can master it and become really bigger than it – you develop – there’s some magic in that.

And how d’you think you were able to do that – feeling overwhelmed and changing and mastering it?

I think that comes with a bit of experience because I remember one of the first very traumatic things that I worked with when I was an intern was a woman who came in and she came in only once, and she said at the beginning of the session she’d come only once. She said to the psychiatrist and to the GP that she doesn’t want to come – she doesn’t believe it will help, but she will come once. Her husband was murdered but very brutally – was tortured very badly and then murdered and then she was told by the paramedics that he had a peaceful expression on his face. But apparently he was a racist – he was white and he was tortured by black people and she didn’t believe what was said that he had a peaceful expression, cos he was tortured and so she was very bitter and very full of hate and she projected that all on to me, and it left me – I feel so shaken I could barely speak in the session. I really could barely speak, and I could just take all of that hate and hate and hate she gave me, and of course she didn’t come back. There

‘Mastery’ in working with trauma comes through experience

Client’s reluctance to come to therapy

Client’s reluctance to work on trauma

Racially motivated torture and killing

Distress at having client’s bitterness and hate projected on to self

Paralysis of being emotionally overwhelmed

Confused tenses with the emotion of retelling

Frustration at not being able

Difficulty working with bitterness/hate following

to soothe this client	was almost no way of comforting this woman or even of	trauma
Inability to relate	holding her; she was just there on her own, spewing fire. And I think that was one of the occasions that I realised that inside	
Needing to gain emotional control / distance from the experience – stepping out	myself I have to be able to step outside of this if I want to do anything about it – and we at the time had training in a bit of NLP techniques, and in the same timeframe I had a young girl who was raped by an officer who said that if she told on him he would commit suicide. And she told on him and he committed suicide, and so she was in a psychiatric ward	Stepping out of emotional pain
Use of particular techniques as empowering	feeling quite disturbed about it. And I decided to use one of these NLP techniques on her and she visualized him coming through the door, and she told him all the things that we spoke about and agreed about before hand, that it wasn't really her fault and it was his choice, and he shouldn't have done it and she made him disappear – turn black and white and use all those techniques, and she was fine after that. She completely	
Client being empowered by technique also	bought into it – it was a very relaxing experience and those two combined – really feeling overwhelmed on the one hand and really feeling empowered on the other hand made me	Empowering techniques – empower client as well
Combining energy and techniques	think that there must be away to combine the two. So I started experimenting with ways of using some of that energy and putting it into new framework for my clients to use, and it	Experiential learning for both self and client
Importance of clients 'buying into' the	worked with some – not with all, and you can get caught up	

therapy
process

really badly if people don't buy into it; but for the most part I think that's where it came from – the starting point of it and it really grew from there.

And that sounds like a real internal journey as well –

'stepping out of' the feeling.

Taking charge
rather than
being
paralysed by
fear

Stepping out of it and really taking charge of it because I think fear can be so overwhelming and disabling really, and it's very easy to step into it and feel the fear of not being able to do anything about it – very paralysed.

'Stepping out'
of feeling of
fear

**So a very physical feeling of fear – and I was thinking
stepping out of it sounds very physical.**

Creating
physical /
sensory
changes in
session

And I do sometimes – I make patients change seats, or I have them sit on the floor which really causes them to wake up in the sessions. Sit on the floor, or we move things. Something I very often do is I'll dim the lights – not in this room but in the hospital where I work – I'll dim the lights; that seems to work lots of magic – people really buy into something if it's in the dark or if it's darker; so there's a lot of creative things that I do.

Trying to
create a
psychological
shift with
physical
change

Working magic
– sense of more
imagination /
creativity in
the dark

And how d'you make sense of that?

Inviting the
client to 'step
out' in order to
work through
trauma

I just try to focus in to change something, and to be able to give them the opportunity to step out of it with me so when I switch on the lights again, we're done with that little piece of

	trauma work.	
	Is there something in there about awareness of the body in that?	
	Very often.	
Locating trauma in the body	Because you were talking about changing position and changing seats.	
Smell of fear	Yeah – I’ll ask them where in the body do they feel the trauma or the fear. I had a gentleman in here – he couldn’t go into London because he was too afraid – he was very traumatized and he witnessed suicide. And you could smell the fear – you	Helpful to locate trauma in the body and help the client be more aware
Physicality of trauma response – sweat, tears, smell of vomit	can smell somebody on the point of vomiting – that smell – you could literally smell the fear when he came in, and he would sit and be drenched in sweat, and if his chair croaked, and it does croak, he would have such a fright and almost	
Making client aware of their body as helpful	burst into tears. And with him, especially, I used a lot of body work, although I kept him in his seat, but I made him aware of his body – aware of where he feels the fear and does he want... what could it be otherwise, and that worked quite well for him.	Awareness of the body
	And that interest in the body comes through your experience of working with trauma, or is that something that was more generally part of the work?	
Importance of awareness of the senses	I think it's both – I think the thing with trauma and especially	Focus on bodily / sensory processes

from the time of the trauma	with the Mitchell model we used, is that there is an awareness of the thoughts and the feelings and emotions, and the senses.	
	So being aware of the senses – what the senses were doing at the time of the trauma – I think that was the starting point for body awareness, and I started to come across it in other fields as well, but that's something that I find really strong – the awareness of the senses; and with this man, smelling his own fear reminded him of the incident, and when I could make him aware of that, that was a really big step forward.	Role of senses as well as body
Awareness of senses as step forward	So it's more than just the physical body – it's all the senses.	Therapeutic value of embodied awareness
	This experience of the physical world.	
	And can you think of a time when you felt that your internal responses changed over time in working with a particular client?	
Initial fear in working with trauma but conscious choice to change this	[Pause] Not that I can think of. When my physical responses changed. Well, initially I did feel a lot of their fear – physically feel it, and it was a very conscious choice not to take that on because you feel extremely [inaudible] if you do. I remember working in a ward – it was a normal orthopaedic ward but I had to go and debrief the whole ward because one of the long-term patients overdosed in the bathroom, and one of the staff members came in. And he was in the ward because	Conscious choice not to absorb fear

<p>Taxing demands of the work when incident happens that have to respond to</p>	<p>he already lost the use of his legs because of drugs, so there was a really – that was a really hard day. I had to see 12 patients – debrief each one of them individually, which was quite hard, and really taking a lot of that physical heaviness because there was no time to stop and off-load. We were quite under-staffed and so there was a conscious choice and I remember afterwards and I tried to get rid of it – that</p>	<p>Physical impact of work – unable to shift it</p>
<p>Trying to leave physical feelings behind through physical movement, but unable to</p>	<p>heaviness and feeling in my body, and I simply couldn't. I went for a very long drive, trying to leave it behind, and it wouldn't and there was a real sense of wanting to rid myself of this heaviness and awfulness, and I couldn't; and I think that was part of me starting to realise how important it is to</p>	<p>Necessity of self-protection</p>
<p>Importance of barriers and safety nets to do this work</p>	<p>put barriers up and safety nets up for myself if I want to be able to continue doing this work. So I think over time, I learned not to take it on as much, but sometimes I do sort of</p>	
<p>Empathy / experience a sensation through the details</p>	<p>feel the sensation, perhaps when it's acutely described – or I had a patient whose grandfather repeatedly raped her across her whole childhood – her father and her grandfather. And she was then forced to hold his hand while he was dying, despite the whole family knowing about this, and she described the way his hand felt in her hand and it was just really going</p>	
<p>Details 'leaking' feelings through – trying to be logical and cognitive to</p>	<p>about it in detail and I really felt yucky afterwards – not wanting to touch my own hand and having to really think</p>	

combat this	about this and be very cognitive and logical about this. So	
Learned to distance self from traumatic details	there are still times when some of it might seep through but I think for the most part I've learned to distance myself a bit more from it.	Distancing self for self-protection
	So in terms of the distancing yourself – are there things you do to keep the distance?	
Giving self breathing space between clients – using the senses – candle / hand-washing / collecting clients	There is – where I worked in [country of origin], I lit a candle between each session to clear the air – not in any magical way – it was a rosemary candle that smelled nice – but just to give myself – and I would wash my hands between sessions as well – just to give myself a breathing space; and I'm very set on getting my clients from reception – I don't have them sent down, to provide a break as well, and sometimes I'll do yoga	Managing the distance / processing through the senses
Yoga stretches to process emotions physically	[laughs] – just a few stretches between clients, if I feel I need to rid myself of stuff I've heard or stuff I experienced; so there are sort of physical things I do. You can't do too much emotionally between patients – in one way I don't really	Use of physical movement to process feelings
Need to process afterwards – no space in-between clients	process a lot of what's happened as its happening – a lot of processing happens afterwards. But I'll be aware that things don't sit well. I had a very strange experience – last year – where a woman from [country of origin] takes – she sent me an email from her Blackberry and she found my email address through my work site, but she's in [country of origin] and I'm	

Becoming emotionally caught up with woman's suicide plan	in the UK and she was going to kill herself, and so of course I'm really alarmed and I try to find out where she is, and if she can get help; and she had a plan and a time – it was very disturbing, and eventually I managed to phone the company she works for and spoke to their HR person and her manager, and they went and spoke to her and got back to me and in lovely [country of origin] fashion – ‘we got her and we prayed with her and she's better now’, which is really the way they start doing things. But I knew she was taken care of and she wasn't my responsibility. but this was 9 a.m. in the morning, and I was at work with a list of clients to see for the rest of the day. So what I did for the next two patients – which were light and stable – was unheard of – I said I think we're gonna walk for your session because I was just too upset really to be able to sit in the room; and so we had walking sessions [laughs] for two of the patients. We walked around the streets, around the hospital while talking about their problems, and the walking helped me focus on the patients at the time without reverting back to the incident earlier in the day; so sometimes, desperate times calls for desperate measures.	Alarm about potential suicide
Importance of knowing that someone has taken the responsibility		
Difficulty of conflicting responsibilities		Difficulty of managing clients needs Simultaneously
Adapting how work with clients to minimise the impact of own emotional distress		
Walking as a way of staying emotionally present with clients	And do you feel that had any impact on the session. It definitely did. Well, I said to both of them – I'm really sorry – I had some really unsettling news this morning, and would it	Minimising impact of own emotions

With both clients suicide was raised

Uncertain whether brought this about – implications of own state of mind

The importance of therapist knowing how to self-care / soothe themselves

Need to be creative

The different ways that clients interpret the same therapist behaviour

be OK if we walked for your session, and they said ‘fine’ because it was a long-term thing, and they took to it and went on with the work that we were doing anyway. But with both of them the topic of suicide did come up.

In both sessions?

Yes, and I’m not quite sure if I steered it or whether it came up but it was quite interesting the viewpoints the patients had from the patient earlier that day, so that was quite – almost soothing in a way to be able to walk with them. So sometimes you had to use what’s at hand if you can’t do something else.

And can you describe any other ways that your response might have had an influence on the therapy with those clients?

One of them I saw – I had to do ten sessions with him because he was badly behaved at work – which he didn’t agree on, and thought was a misunderstanding, but he was quite focused on the incident at work and convincing me about his plea so he wasn’t too in touch with the rest of his process – he was very involved in his own process, so the next time he was like, well, whatever...are we gonna walk today or not? And the other patient was – she was lovely, but she was also very ill so she didn’t have a big awareness of people around her, and I think she thought that it was more for her benefit than mine,

Importance of self-care

Uncertainty about whose subjectivity is bringing in particular issues

	so I'm not quite sure it had a long-term effect.	
	So she interpreted it as something useful for her.	
Unintended benefits	Also because she was an in-patient at the hospital, walking is quite beneficial.	Self-care
	When feelings seep in as you described – how do you work with that?	
	I don't necessarily give feedback to the patient in trauma work. I read a really good little paragraph a while back about working with trauma, and that we as the healers really have the capacity to harm even more than the original perpetrators do. I'm very careful of giving them feedback on my feelings.	Capacity of therapist to harm
Caution: aware of possible harm can do as therapist – capacity to harm even more than original trauma	And in those instances I'm much more of a container, and much less of a reflective person. I would never give feedback about how I felt yucky about the hand – she was so fragile as it was, and feeling so awful about herself as it was – the idea that she could contaminate somebody else would break her,	Concern about impact of own feelings on the client
Concern about how own subjectivity may impact on the client	really, so for me the reflective part becomes very small in trauma work and the holding part very big. Unless it's very useful – I found it useful at the end of the therapy with the man with the smell to tell him – initially when you came in, I could actually smell your fear, and its great that I can't any more, and I wonder how it feels that you don't smell your own fear any more? So I could use that right at the end, when he	Client fragility – so important not to know could contaminate with trauma
More containment and less reflection in work with trauma		
Unhelpful for client to think could contaminate		
Reflection at end when client is less		Emphasis on containment rather than interpersonal process

fragmented
and more
contained

was much more contained and much less fragmented as they
are in trauma work.

**So a sense that you are there as the holder and their
process is the focus?**

Aware of own
internal
processes but
not explicitly
reflected upon
with client

Yes – and I might notice things in myself, but there is no use
for them reflecting it. They don't need to learn anything from
it unless what they're doing is they're retraumatising people
around them, which you rarely get, but in people with
personality disorders – they like to spread bad news, so in a
group situation you might say – when you spread that in such
a way, it might be quite damaging for people to hear, but in a
one-to-one session I find just being a container is often
enough.

Own self-
reflections
not explicitly
shared with
client

Only use
reflection if
client is re-
traumatising
others

And so does that differ in non-trauma?

Oh yes – it's very different – it's really very different when
you have that fragmented person – or when you have a person
with a part that's really fragmented, then you might reflect on
the part that's well enough to take it. But when there's fragile
parts, you really have to be very careful with that – how you
go about it, and how you help them look at it, and even how
you take charge of it. And I think one of the ways to be
respectful in it is to use their language – the words they use to
describe it – because we have such different meanings for the

Fragility –
trauma linked
to
fragmentation

Trauma
linked with
fragility and
fragment-
ation

Working by
assessing
capacities of
different parts
of clients

Importance
of assessment
of client's
fragility

Taking charge

Importance of
respectfulness

Importance of language and using client language	same words, so one of the things that comes very strongly	Working therapeutically with use of language
Offering client language with a survivor focus	from my training in [country of origin] that I really liked to do is, I ask people if its OK if we talk about them being a trauma survivor rather than a trauma victim – there’s such a different focus on it. And there’s people living with trauma instead of just trauma victim, so there’s different ways of phrasing it	
Language has implications for how conceptualise a client’s issues – puts self in less of a rescuer role and highlights client’s survival strength	which could be empowering as well. It changes the way you think about the patient as well, cos instead of thinking you’ve got to rescue them, you think of them as having survived this; you can hold them and guide them though the process, but ultimately they’ve already survived this, and they probably had it in themselves to survive more.	Addressing power in the therapy relationship
	Has that aspect of your response changed?	
Importance of training in terms of interest in language	That really comes very strongly from my training – the language part specifically – I was trained very post-modernism and constructivism so there was a big emphasis on language also because [country of origin] has eleven official	Influence of training and work context on focus on language
Context of multi-lingual society	languages so you have to be very aware of the use of language – we might share English but we don’t have the same meanings attached to the words. Or we might not share a language. And we have to use a different type of language or understanding which is a whole different thing to talk about	
Language creating different understandings	but very important in the way you work with people. I think	Role of language in creating meaning
Importance of		

use of language in working with people	one of the things – one of the biggest parts of our training was	
	of course HIV-AIDS – doing AIDS counselling, pre- and	
	post- test counselling, grief, bereavement – the whole	
Overt political correctness of various labels	caboodle. And politically in [country of origin] it's incorrect	
	to speak about AIDS victims – it's a person living with HIV-	Use of 'politically correct' language
	AIDS. You don't speak about rape victims – 'survivor of	
	rape', so there's also a political correctness in the way you	
Respect demonstrated through language	express it, but I like the underlying psychological meaning	
	attached to it and I think it's really important to show your	
	clients some sort of respect – to ask if its OK if we rephrase it	
Importance of language to the success of therapy, to the relationship and to the relationship with themselves	that way. And I've found that people were with three or four	
	different counsellors and I had a psychologist there send them	
	on to me – that just a different way of phrasing it already	
	makes them listen differently to you or view themselves	
	differently.	
	That sounds key.	
Pathologising messages in relation to trauma	I think it is because they go to a counsellor who says 'I'll do	
	trauma counselling with you', and they sort of go away with	Counteracting pathologising attitudes to trauma
	the information that I'll never get better cos I'm a victim of	
	trauma, and people get told this will stay with you for the rest	
The possibility of emotional liberation from trauma	of your life. Well the memory could, but the emotional impact	Possibility of healing
	doesn't need to. But its such an artificial thing being imposed	
	on you that it can be lifted. If it takes 5 minutes for you to	

	change the way you feel about dogs because a dog bit you, well maybe it will take 5 sessions but you could change that again.	
	What is your most positive experience in working with clients who've experienced trauma?	
Possibility of creating real change in work with trauma	I think, seeing that real change which you don't necessarily see working with something long term, or if it happens in a long-term thing it doesn't necessarily come back (inaudible). But sometimes you change literally from the beginning of the session to the end of the session, where you have contained somebody enough, when you've given them a bit of scope, a bit of structure. I think there's a huge reward in work that's usually quite long term to see such a quick short-term change. So that's probably part of MacDonald's culture just doing it quickly. What else do I find rewarding? I like the fact that with trauma work you can really make a difference. You	Desire to see significant change
Unusual change in shorter time with trauma	literally change people's lives – which is part of the narcissistic part of me – but you literally – you change people's lives by guiding them, by giving them such basic tools you can make such a huge difference. And I think that's part of the biggest part of the reward for working with trauma, it's just that ability to bring change.	
Ability to make a significant change in work with trauma – tempting for narcissistic part of self		Therapist's narcissism
Basic tools can make a huge difference – this is very rewarding	And is there a particular client you can think of?	Highly rewarding to bring about change

Impact of trauma reduced client to 'nothing'	I think there were quite a few that was quite positive. Recently	
External constraints of only 6 sessions	I had a person who works with trains and I was counselling them before, sent by the train company to me. And he's been off work for more than two years after an incident – he couldn't save somebody who was jumping on the tracks. And this man was completely – he was reduced to nothing, and I had just six sessions – that's all they would allow to work with him, so the pressure was really on. In the first session – I was quite scared of him – he's a huge, huge bloke. And generations of working on trains, missing a few teeth, tattoos	Time pressure in time-limited therapy
Fear of client	all over the place, skin head, really scary figure. Later on I discovered that was all projection because it was the first time	Client inspiring fear in therapist
Client both scared and scary	in 12 years he dared to come into London, so he was quite	
Challenge of working creatively and spontaneously under time pressure	scared coming. I had to work extremely structured and extremely self-assured with him, and a lot of it was on-the-spot thinking and creative work. But the change I saw within him in six sessions – it was amazing – it almost put me in	
Emotional impact of witnessing the extent of change in short period of time	tears – just to see how he went from this extremely scared and then also scary figure to somebody who became level-headed and really started believing in himself, eager to go back to	
Excitement about positive psychological changes	work. And I had a good report back from the train company so there was some real change happening, and I think one of the	Excitement and emotion about positive psychological changes
Both have a sense of conviction about the	biggest parts of it was just because I bought in to the process	

psychological work	as much as he did. I knew the pressure was on and he knew it	
Motivating pressure	was on – it was sort of his last chance and there was – the work that we did was quite amazing, and how actually scared	
Appreciation of collaborative engagement in the work	someone can be of their thoughts – how he was whimpering – literally whimpering being confronted with some of these thoughts, and then how he challenged that and mastered that.	
Amazement at change in short time	It literally took six sessions and he was home and away - an absolute free man. Which is such a difference.	Collaborative engagement in the work
Psychological freedom	And you said you were quite structured – was that to do with the way he presented?	
Focussed nature of work	I think part of it was his own chaos and part of it was the fact we had six sessions so I really thought I needed to be focused	
No time for 'softer' exploratory work	– there is no time for touchy-feely stuff – we need to be working. So we did a lot of hard work – much more like the work I did in [country of origin], actually, because of the time	
No time for anything tangential	constraint. You know, if you have 12 to 20 sessions you can let people talk about other things as well as do trauma work, but with this bloke he just really – he came – he was so scared	No time for exploratory work
Appreciation of client's bravery	– he was shaking, absolutely shaking – but he did – he was very brave, so that was very rewarding.	
	And talking about short-term / long-term work – was that from a particular therapeutic orientation?	Appreciation of client's qualities
Less humanistic	Erm, I guess there's a lot less Rogers in it, or Freud.	

when therapy is short term	Sometimes I'll use a bit of CBT – trauma-focused CBT	
Working to NICE guidelines	because that's the NICE guidelines. But to be very honest with you I just use a lot of gut work. And a lot of creative work, and I really try to see where the session takes me and try to gauge the level at which the client can take challenge.	Competing influences – NICE guidelines, gut and use of self' and responding to session
Valuing gut work and creativity	And really work with that, and try not to overplay my hand but really work with full strength all the time. So that's – I guess, that's the framework - gut work.	Valuing 'use of self'
Trying not to overestimate self	And could you describe your most negative experience in working with trauma?	
Assessing what client can take	Er, the most negative [pause]. I can't think of a particular one – there's probably millions – but I can think of an instance where if I work with a client and they hold on to the trauma – they have no desire of letting go, and it becomes a real sticky object between us. Or they will disclose that there is a trauma but we can't go there, and it comes up all the time as a secret or a thing in the way of the therapy; that's quite difficult – quite frustrating. So I recently worked with a woman who had a very traumatic experience of an abortion – and I'm pregnant, so that was very hard to hear for me – sort of thinking, I really don't want to hear this now. But of course she didn't know I was pregnant. I've been seeing her for ages so that was quite an unsettling experience, but I did manage to do a little bit of	
Difficulty in work of client having a psychological need for trauma		Difficulty when trauma 'used' to keep therapist at a distance
Ways that trauma keeps therapy and therapist at a distance		
Also difficult when share biographic details with a client		Difficult when client and therapist share biographic details
Worked on senses more and meanings less		

Working with senses when can't talk about trauma	trauma work with her around it. Just around the senses – how – which actually proved to be extremely helpful because instead of us focusing on the trauma as it happened, we focused on the senses, which is something I learned when I worked with the special forces in the military. They aren't allowed to talk about the traumas – they're trained not to talk about anything, but you talk about what did the trees look like, what did it smell like – can you tell me the colour of the grass? Those sorts of things they are allowed to talk about, of course. So I learned how to talk about trauma without actually	Not addressing meanings of trauma but focussing on the senses
Keeping trauma at a distance for own self-protection	addressing the trauma, and that's all the techniques I used with her. And that helped a lot for her to open up without actually having to delve into the trauma too much.	Self-protection
Fear of the fragility of clients in pushing them too much	<p>Is there anything you feel that's helped or hindered the way that you work with your internal responses?</p> <p>Er, I guess there's often a fear that I've overplayed my hand. There's often a fear that have I pushed them too far – how is this going? – are they going to be alright? I'm very aware of containing clients afterwards – that's an extremely important part for me – if we have worked with trauma, I leave 20</p>	Importance of containing clients
Importance of containment when working with trauma	minutes for the containing part. Of course clients won't really disclose until there's only ten minutes left so it's a bit of a fine	Satisfying work with
Satisfaction of working using	dichotomy. But I think working with my internal processes,	

internal processes – gut and creativity	it's really been good trusting my gut and trusting my creativity. And I will fall back on theory when I feel at a loss.	use of self
Theory as a fall-back when uncertain in use of self	I think what's good about that is it allows you to engage on a connected level, but that's what allows traumas to seep in sort of in a countertransference way where I might feel a bit of their fear or I might feel... and then I sit with that and have to do that. So sometimes being too much of a container can be damaging to the therapist.	Value of engaging in a connected way with clients but danger of being damaged / contaminated by this
Countertransference and feeling the client's fear	And in terms of what you were saying about gut and creativity, what's helped you to do that?	
Motivated to learn through fear	Fear. [laughs] I think I was trained in a way to use a lot of my gut feel and I've always been quite creative, so I've always wanted to use that in therapy – I think a lot of it was born out	Creativity born out of need
Creativity born out of needing to respond to uncertain situations	of need because we did have all this trauma to deal with as trainees, and didn't really have the tools to deal with it, so you develop a framework for yourself to help you cope with it because if you just try to go by the book, that's not enough.	
Not enough to go by theory alone	And I think then when you get a positive result you start to build on some of the techniques – start to build confidence in	Confidence gained through experience
Building confidence in abilities through experience	'oh yeah, I could really use this here – this seemed to work well'. And then next time you feel a bit more convinced when	
Importance of own conviction for clients – not possible to work using	you tell the patient, and the patient buys into it a bit more. So there is that. I'm not good using anything I don't believe in.	Need for belief in methods

methods don't believe in

And in terms of the creative part, is that something that was always there?

Yeah.

Have your subjective responses changed over time with trauma?

More distanced and calm over time in working with trauma

Oh definitely. I've managed to distance myself a bit more – be a bit more calm myself, not as anxious when trauma came up.

Extent of anxiety with trauma when in training – paralysing

I think initially when I was an intern especially, I felt so much anxiety I could barely speak back - probably not that bad

Now better able to digest trauma

[laughs]. But you definitely develop a sense of calm – being able to listen, to take a second to digest. And sometimes to not react. Which is something that I'm playing with – not to be

Using non-responsiveness with trauma to allow fresh feelings to come up

unsympathetic, but sometimes you know when everybody else has been going 'Ooo – oh my goodness', to have somebody go 'sure' and just leave it there opens a different avenue for somebody to talk about it in a different way, or feel about it in a different way.

So almost not sort of giving a socially expected response opens up something?

Allowing a client to get closer to what they genuinely feel

Yes – which I think is sometimes really important. Without coming across as unsympathetic, but by giving them a space to sort of *really* say what they feel.

I've come to the end of my questions – is there anything I

Significant changes over time in responses to trauma

Experimentation with use of responses with trauma

Trauma is an aspect of any psychology service

Problematic if therapists aren't trained / don't see themselves as competent to work with trauma

Fortunate to have had specific training – better able to cope

Trauma training essential to all counselling psychologists

Colleagues not prepared to work with trauma because not trained and view it as a different field

Trauma comes up in therapy – therapists need to be able to deal with it

haven't asked that you feel is important to the topic?

Erm, no. I think the interesting thing about trauma work is in a way it's part of every practice, and I think it's sad or a shame if people aren't trained in it quite well to be able to deal with it as it comes along. I feel very fortunate that I've had training, so I am able to cope with it when it comes along and especially when there's a huge trauma being dumped on you at an unexpected time, to be able to really fall back on the theory until you're back on your feet. So I think it's an essential part of training and I hope, all things being equal, enough people get trained in it, counselling psychologists, because it will come up.

So is there from your experience a lack of trauma training within counselling psychology?

Yeah – from my colleagues I find that they don't do trauma cos they've not been trained in trauma, and they see trauma as a completely different field and very specialist. And actually it does come up in therapy – it does come up in a normal just run-of-the-mill work, and you have to be able to manage it – even if it's just from a theoretical point of view, to be able to deal with it effectively, I think.

Trauma in all psychology work

Value of specific training in trauma

Importance of having the skills to work with trauma

APPENDIX 8: LIST OF THEMES FOR INTERVIEW FOUR

Training oriented towards trauma
Trauma models linked to the military
Hardiness needed when working with trauma
Traumas different in different contexts
Preference for working with fewer trauma cases
Changes in identity through working with trauma
Hierarchy of traumas
Harsh training necessary for extreme trauma
Extreme challenges of training
Training damaging the students
Questioning the ethics of training methods
Context defining way in which work with trauma
Subjectivity of what is traumatic for people in different contexts
Recalibrating empathy in different contexts of trauma
Contextual changes in expectations about trauma
Contextual differences in pressures for resolving trauma
Value of having more time to work with trauma
Different traumas resonate differently
Changes over time in internal responses to trauma
Working with negative energy and mastering it
'Mastery' in working with trauma comes through experience
Client's reluctance to work on trauma
Paralysis of being emotionally overwhelmed
Difficulty working with bitterness/hate following trauma
Stepping out of emotional pain
Empowering techniques – empower client as well
Experiential learning for both self and client
'Stepping out' of feeling of fear
Trying to create a psychological shift with physical change
Helpful to locate trauma in the body and help the client be more aware
Awareness of the body
Focus on bodily / sensory processes
Role of senses as well as body
Therapeutic value of embodied awareness
Conscious choice not to absorb fear
Physical impact of work – unable to shift it
Necessity of self-protection
Distancing self for self-protection
Managing the distance / processing through the senses

Use of physical movement to process feelings
 Alarm about potential suicide
 Difficulty of managing different clients' needs simultaneously
 Minimising impact of own emotions
 Importance of self-care
 Uncertainty about whose subjectivity is bringing in particular issues
 Self-care
 Capacity of therapist to harm
 Concern about impact of own feelings on the client
 Client fragility – so important not to know could contaminate with trauma
 Emphasis on containment rather than interpersonal process
 Own self-reflections not explicitly shared with client
 Trauma linked with fragility and fragmentation
 Importance of assessment of client's fragility
 Working therapeutically with use of language
 Addressing power in the therapy relationship
 Influence of training and work context on focus on language
 Role of language in creating meaning
 Use of 'politically correct' language
 Counteracting pathologising attitudes to trauma
 Possibility of healing
 Desire to see significant change
 Therapist's narcissism
 Highly rewarding to bring about change
 Time pressure in time-limited therapy
 Client inspiring fear in therapist
 Excitement and emotion about positive psychological changes
 Collaborative engagement in the work
 No time for exploratory work
 Appreciation of client's qualities
 Competing influences – NICE guidelines, gut and use of self and responding to session
 Valuing 'use of self'
 Difficulty when trauma 'used' to keep therapist at a distance
 Difficult when client and therapist share biographic details
 Not addressing meanings of trauma but focussing on the senses
 Self-protection
 Importance of containing clients
 Satisfying work with use of self
 Value of engaging in a connected way with clients but danger of being damaged /
 contaminated by this
 Creativity born out of need

Confidence gained through experience
Need for belief in methods
Significant changes over time in responses to trauma
Experimentation with use of responses with trauma
Trauma in all psychology work
Value of specific training in trauma
Importance of having the skills to work with trauma

APPENDIX 9: THEME TABLE FOR INTERVIEW FOUR

Themes	Page	Key words
The contextual nature of trauma		
Traumas different in different contexts	1	it suited the environment
Hierarchy of traumas	3	little things in their eyes
Subjectivity of what is traumatic for people in different contexts	4	that that is just as traumatic
Context defining way in which work with trauma	4	if you practise in...there's not really a choice
Recalibrating empathy in different contexts of trauma	4	developing the empathy for that
Contextual differences in pressures for resolving trauma	5	a sense of urgency... there's much more 'take your time'
Different traumas resonate differently	6	there was something about it that felt a bit personal
Role of language in creating meaning	18	we have to use a different type of language or understanding
Use of 'politically correct' language	18	there's also a political correctness in the way you express it
Working therapeutically with use of language	17	use their language
Personal journey to develop responses to trauma		
Changes over time in internal responses to trauma	7	initially when I worked with trauma there was a lot of anxiety
'Mastery' in working with trauma comes through experience	7	I think that comes with a bit of experience
Experiential learning for both self and client	9	experimenting with ways... for my clients to use
Confidence gained through experience	24	start to build confidence
Valuing 'use of self'	22	I guess, that's the framework - gut work
Significant changes over time in responses to trauma	25	initially...I felt so much anxiety
Experimentation with use of responses with trauma	25	opens a different avenue for somebody to talk about it in a different way

Changes in identity through working with trauma	2	You get a bit like a paramedic
Paralysis of being emotionally overwhelmed	8	I feel so shaken I could barely speak in the session
Difficulty working with bitterness/hate following trauma	8	There was almost no way of comforting this woman
Stepping out of emotional pain	8	I have to be able to step outside of this
Necessity of self-protection	12	how important it is to put barriers up and safety nets
Distancing self for self-protection	13	I've learned to distance myself
Client inspiring fear in therapist	20	skin head, really scary figure
Preference for working with fewer trauma cases	5	it's much better when you only have one or two trauma clients at a time
'Stepping out' of feeling of fear	9	Stepping out of it
Importance of self-care	14	Helped me focus
Conscious choice not to absorb fear	11	It was a very conscious choice
Challenging processes when working with trauma		
Value of having more time to work with trauma	6	allows you as a psychologist to take a step back
Working with negative energy and mastering it	7	using this very negative energy and having to master
Client's reluctance to work on trauma	7	she doesn't want to come
Value of engaging in a connected way with clients but danger of being damaged / contaminated by this	24	sometimes being too much of a container can be damaging
Creativity born out of need	24	a lot of it was born out of need
Hardiness needed when working with trauma	1	you really had to stand your ground and be steeled
Empowering techniques – empower client as well	9	really feeling empowered
Alarm about potential suicide	14	It was very disturbing
Difficulty of managing different clients' needs simultaneously	14	I was just too upset really
Minimising impact of own emotions	14	desperate times calls for desperate measures
Uncertainty about whose subjectivity is bringing in particular issues	15	I'm not quite sure if I steered

Capacity of therapist to harm	16	healers really have the capacity to harm
Concern about impact of own feelings on the client	16	careful of giving them feedback on my feelings
Client fragility – so important not to know could contaminate with trauma	16	she was so fragile
Emphasis on containment rather than interpersonal process	16	much more contained
Own self-reflections not explicitly shared with client	16	there is no use for them reflecting it
Trauma linked with fragility and fragmentation	17	that fragmented person
Importance of assessment of client's fragility	17	when there's fragile parts, you really have to be very careful with that
Difficulty when trauma 'used' to keep therapist at a distance	22	It becomes a real sticky object between us
Difficult when client and therapist share biographic details	22	That was very hard to hear for me
Competing influences – NICE guidelines, gut and use of self' and responding to session	22	I just use a lot of gut work
Issues in training		
Training oriented towards trauma	1	we do trauma training specifically
Trauma models linked to the military	1	It was very military like
Harsh training necessary for extreme trauma	3	it was quite necessary
Extreme challenges of training	3	it was absolutely shocking,
Training damaging the students	4	damaging to... the students
Questioning the ethics of training methods	4	there's some things I think as a student you probably don't need to be exposed
Value of specific training in trauma	26	it's an essential part of training
Importance of having the skills to work with trauma	26	you have to be able to manage it
Influence of training on focus on language	18	there was a big emphasis on language
Working with the body		
Trying to create a psychological shift	9	I'll dim the lights; that seems to

with physical change		work lots of magic
Helpful to locate trauma in the body and help the client be more aware	10	I'll ask them where in the body
Awareness of the body	10	I made him aware of his body
Focus on bodily / sensory processes	11	being aware of the senses
Therapeutic value of embodied awareness	11	that was a really big step forward
Physical impact of work – unable to shift it	12	I tried to get rid of it
Use of physical movement to process feelings	13	there are sort of physical things I do.
Managing the distance / processing through the senses	13	I lit a candle between each session
Not addressing meanings of trauma but focussing on the senses	23	we focused on the senses
Appreciating the use of self in the therapy process		
Highly rewarding to bring about change	20	the biggest part of the reward... ability to bring change
Excitement and emotion about positive psychological changes	21	it was amazing – it almost put me in tears
Satisfying work with use of self	24	it's really been good trusting my gut
Desire to see significant change	19	seeing that real change
Counteracting pathologising attitudes to trauma	19	they sort of go away with the information that I'll never get better
Importance of containing clients	23	I'm very aware of containing clients
Addressing power in the therapy relationship	17	Could be empowering
Possibility of healing	19	you could change that again
Therapist's narcissism	20	the narcissistic part of me

APPENDIX 10: REFLECTIVE JOURNAL EXTRACTS

June 27th 2010: *Journal summary following ‘self-interview’:*

I experience working with trauma as highly involving with a sense of momentousness about the process of the client sharing what has perhaps been previously unexpressed, and being a witness to this process. I was also aware of a sense of trying to communicate my sense interest and valuing of the client’s sense of self. In this way I also had an awareness of trying to offer the possibility of a new relational experience, as well as the importance of my responses. I was reflective about the quality of physical engagement. I was also unsure about how my feelings of anger and also care, might impact on the therapy.

In my therapeutic work, there is also an emphasis on trying to stay closely with the client’s experiencing and trying to put into words what might be going on for them. At moments I also thought it was valuable to share my subjectivity with the client. I also experienced the difficulty of not being able to provide relief. It was important to me to try to following the client’s lead rather than following a model.

I value highly the client’s communication of what they gained from the therapy. I am also concerned about the limitations of psychology in helping someone with wider problems in life, and the need for wider network of support. In my experience, the ‘depth’ of work with clients is facilitated by the nature of the supervision relationship and I found it difficult when there seems to be a lack of intersubjective understanding in supervision.

I start from the assumption that I am emotionally affected by the work. And yet, at times, I also found it difficult to share my experiences in supervision groups and felt concerned about the impact on others. I feel teaching and discussion about how to use responses our responses to trauma is somewhat neglected in training.

August 28th 2010: *Post-interview notes:*

As Serra described a story she’d heard, she stated “even thinking about it now I get emotional” and the emotion was visible to me, and in response I did feel a sense of sadness that seemed to be in witnessing Serra’s emotion rather than the story itself. As well as feeling a sense of sadness, I also felt an emotional closeness to her at that point – both for sharing something she expected would be professionally ‘frowned upon’ and also in her own sharing of emotion. I wonder if that might demonstrate something of what she describes as the value of her own emotional openness with her clients.

April 1st 2011:

There’s a sense for me of something I was looking for in the participant’s accounts that I didn’t find, like a found wisdom or vicarious post-traumatic growth or something.

Reading my initial analysis I wonder how one is able to find a place of acceptance for trauma. The paradox is that participants talk about needing to lighten the caseload, but also that gaining experience helps them find a ‘place’ for traumatic stories and to gain confidence. Possibly it’s about having enough time to process stories? I wonder what it means to create a space in the self where stories can be accepted at some level –

something has to shift – what is this? – wisdom? – what are the barriers to acceptance? – shame at ourselves? For me there is a yearning to find a place for some of the things I’ve heard, and a desire for this not to be a quietism in the face of oppression - the anger has a place too.

June 20th 2011:

I was reflecting on the issue of post traumatic growth in the study and my idea that I didn’t ‘find it’. Then I wondered about my own growth through the study. On reflection, through the research I ‘got over’ my fear that I wouldn’t be able to handle traumatic stories, and I feel more confident in my ability to take in awful stories and have a sense of acceptance about what happened. I was touched by how the participants were touched by their clients’ stories and I had a sense of common humanity about this that I valued. I feel I gained more maturity in myself – to be able to be thinking and feeling in response to trauma – in therapy work but also in life more generally, when I hear things on the news or that people share with me. That whilst I may feel angry and indignant – I may also be thoughtful. I feel I’ve gained a greater openness to many meanings of trauma. I also have a greater sense of hope. I wonder why this is? What I also find interesting is that whilst I was aware of what I found difficult (e.g hearing some of the stories), and was aware of this immediately, I was not aware of these gains explicitly. I had to deliberately reflect on what I had gained to come up with them. Is there something about a greater focus on what is difficult when working with trauma? It was certainly the focus in participant’s accounts.

APPENDIX 11: TABLE OF THEME PREVALENCE AND EXTRACT SELECTION

Superordinate themes in bold Subthemes in standard text	Prevalence of theme (number of participants represented in theme)	Extracts provided in support of theme (number of participants in brackets)
Demands and challenges in the use of self in response to trauma		
'It's just horrific': The difficulty of bearing the pain of trauma	9	Beth, Nadia, Elisa, Timothy. (4)
Stepping in or stepping out?: Dilemmas in working with own emotional responses	9	Rachel, Lydia, Timothy, Lucy, Serra, Elisa, Michail, Beth. (8)
Negotiating complex interpersonal dynamics	7	Elisa, Beth, Lucy, Serra, Michail, Timothy. (7)
Dimensions of complexity in working with trauma: Conceptual, contextual, ethical, political		
Grappling with unstable conceptualisations of trauma	5	Michail, Serra, Lydia, Elisa, Rachel. (5)
Grappling with trauma in context	6	Beth, Elisa, Lucy, Michail, Rachel. (5)
Grappling with moral and ethical dimensions of trauma	4	Timothy, Rachel, Beth, Michail. (4)
Developing the therapeutic self in response to trauma		
'Somehow you have to go through hell and back': Changes to the self through working with trauma	9	Serra, Nadia, Lucy, Rachel. (4)
Learning from others	9	Lydia, Serra, Michail, Rachel. (4)
'You have to find a way to resolve that in yourself': Reaching a place of acceptance and hope	5	Nadia, Beth, Lucy, Rachel. (4)
Valuing the therapeutic self in work		

with trauma		
'I was just being with him, to be honest': Valuing personal qualities in work with trauma	9	Beth, Elisa, Timothy, Rachel, Michail. (6)
'Making sure you know where you're at': Valuing self-awareness in work with trauma	4	Michail, Beth, Serra. (3)
'Its about psychologically keeping yourself safe': Valuing self-care in work with trauma	6	Beth, Lucy, Elisa, Rachel. (4)